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TESTING DIFFERENCES:

THE IMPLEMENTATION OF WESTERN HIV TESTING NORMS

IN SUB-SAHARAN AFRICA

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IN SUB-SAHARAN AFRICA

by

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Dedication

To Daddy Norman

Acknowledgments

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President. He has shown me, by example, the rewards that hard work will bring. It is to him, and in his memory, that I dedicate this dissertation.

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TESTING DIFFERENCES:

THE IMPLEMENTATION OF WESTERN HIV TESTING NORMS

IN SUB-SAHARAN AFRICA

Nicole Catherine Angotti, Ph.D.

The University of Texas at Austin, 2010

Supervisor: Mark D. Regnerus

This dissertation considers how Western health interventions are incorporated in non-Western societies. It focuses specifically on 'HIV Testing,' a key strategy that emerged to fight the spread of HIV in the West and was later institutionalized globally and exported to other, very different parts of the world. The empirical object of study is the "3Cs," the cluster of Western norms and ideals upon which global testing policy rests: (1) that it includes *counseling*, (2) that it be conducted with informed *consent*, and (3) that the test results be *confidential*. Employing several methods of field research, this project investigates how the rationalities and motivations of various actors at national and local levels affect the implementation of a key global AIDS intervention in Malawi, a high HIV prevalence, rural African setting.

Fundamental differences between the West and sub-Saharan Africa form the basis of this inquiry as to how imported models fare when implemented outside of their context of origin. Towards that end, this study considers how three strata of social and institutional actors who inform the HIV Testing encounter in Malawi interpret, and put

into practice, the same ideas: the Counseling and Testing Establishment (CTE), HIV Counselors, and rural Malawians. For the CTE, its *proponents,* the "3Cs" are Western, human rights imports that are worth defending formally, but not necessarily worth prioritizing in practice. For HIV Counselors, its *implementers*, knowledge of the "3Cs" as Western biomedical jargon distinguishes them from villagers, but places them in situations where the ethics of testing conflict with moral concerns they have for those whom they were trained to help; thus they adapt them in practice. And for rural Malawians, its *beneficiaries*, the "3Cs" have little inherent value, and are perceived largely as doing harm rather than good in their communities.

Thus, the net contribution of this study is that the "3Cs" have no single meaning as a normative testing regime, but rather acquire (differential) meaning (and import) during their implementation. Indeed, unless policy makers and analysts know something about this, interventions developed from afar are unlikely to have their intended effects on the ground.

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Glossary of Terms

AIDS- Acquired immune-deficiency syndrome

ANC- Antenatal clinic

Ankhowses – marriage counselors, usually an aunt

ART/ARV– Antiretroviral treatment/Antiretrovirals

Azungu- Chichewa expression for "foreigners"

Chokolo – cultural practice of wife inheritance

CDC- Centers for Disease Control

CD4 count – a measurement for how HIV has affected the immune system; how low a CD4 count is determines ART eligibility

CHAM- Christian Health Association of Malawi

Chichewa – Malawi's *lingua franca*

Chinsisi – Chichewa for "secret"

Chitenji – long fabric skirts worn by rural Malawian women

CT- Counseling and Testing

CTE – Counseling and Testing Establishment

DAC- District AIDS Coordinator

DCT- Diagnostic Counseling and Testing

DHO- District Health Officer

Edzi – Chichewa for "AIDS"

Fisi – cultural practice in which another man assists to impregnate one's wife

Global Fund – Global Fund to Fight AIDS, Tuberculosis and Malaria

GPA- Global Programme on AIDS

Health passport/passbook – small yellow medical record that individuals maintain (in the absence of centralized medical records)

HIV- Human immunodeficiency virus

HSA – Health Surveillance Assistant

HTC – HIV Testing and Counseling

Lessons – counseling (e.g., ART lessons)

Kachirombo – Chichewa for "HIV"

Magazi- Chichewa for "blood"

MOH – Ministry of Health

Movious – a term used locally to describe individuals who have multiple sexual partners

MTCT – Mother-to-Child Transmission

Muli bwanji – standard Chichewa greeting for "How are you?"

NAC – National AIDS Commission

NGO- non-governmental organization

Non-reactive – HIV negative

Nsima – Malawi's staple dish made of cornmeal

Opt-in – clients are offered an HIV test by a health provider

Opt-out – clients are tested for HIV by a health provider with the option to refuse

PEPFAR- U.S. President's Emergency Plan for AIDS Relief

PITC- Provider-Initiated Testing and Counseling

PMTCT- Prevention of Mother-to-Child Transmission

Reactive – HIV positive

Refreshers—short training courses

RCT- Routine Counseling and Testing

SSA – Sub-Saharan Africa

STI/STD- Sexually transmitted infection/disease

Takulirana- Chichewa expression for "accustomed to one another"

"3Cs" – Consent, Confidentiality and Counseling

UNAIDS- Joint United Nations Programme on HIV/AIDS

USAID- United States Agency for International Development

VCT- Voluntary Counseling and Testing

WHO – World Health Organization

Window period- the amount of time it takes for the body to develop antibodies to HIV

Wzungu – Chichewa expression for "foreigner"

Zikomo kwambiri – Chichewa expression for "Thank you very much"

Chapter 1
Introduction: Testing Differences

It is the first day of HIV Counselor training. In the training classroom, 25 school desks are lined along the walls, forming a semi-circle. The training facilitators-- Charity and Mary-- are at the head of the room, with a medium-sized projector screen behind them. They begin the session with the first slide, which reviews the course objectives for the ensuing three weeks. The 20 trainees, ranging in ages from 20-45, are sitting straightly in their school desks, focused attentively on the screen in front of them. Charity, dressed in a burnt orange business suit and black leather pumps, paces the front of the room with an occasional kick of the heel, commanding attention with her robust presence. She reads aloud the objectives of the training course, listed in bullet form on the screen behind her:

- Discuss the importance of counseling
- Self-awareness in HIV counseling
- Explain how HIV affects the immune system, using clear, simple terms
- Clearly explain how HIV is transmitted
- Describe the impact of psycho-social issues in counseling
- Apply several important counseling theories to counseling practice
- Explain steps 1-4 of HTC pre-test counseling
- Describe a client's HIV risk
- Explain client-centered strategies to reduce HIV risk
- Demonstrate effective communication skills while conducting pre-test counseling and delivering test results
- Demonstrate and explain whole blood HIV rapid testing
- Demonstrate proper quality control procedures
- Lab safety precautions with particular emphasis on preventing infection through handling of body fluids
- Explain the importance of quality assurance in HTC
- Explain proper management of inventory
- Explain steps 5-8 of HTC post-test counseling protocol
- Explain appropriate HIV support and care services to clients
- Demonstrate appropriate counseling for couples, youth and children

- Describe WHO guidelines regarding ethics in HTC

Charity asks the participants if they have any questions before proceeding to the first lesson. The only question comes from Alex, a participant in his late-20s, dressed in a blue dress shirt and black pants that are a bit too big for his skinny waist. Earnestly, he asks the facilitator, 'What is *ethics*?' Charity, smiling broadly with a sense of purpose and a tint of condescension, replies, 'When the time comes, we will tell you.'

At the end of the second week of training, the time came. In an open group discussion on the major themes of the training course, Memory, a participant of no more than 20 years old, with a striking overbite and thick maroon braids, asks a question of the facilitators in Chichewa. In English, Charity responds, 'It is *unethical* to test your own blood…you are supposed to undergo counseling and testing…where is the [other HIV] Counselor to offer [you] support?'

Alex's question of Charity, Charity's response to Alex, and Charity's final explanation to the HIV Counselor training class are a snap-shot of two phenomena integral to the pages that follow. First, it is an illustration of the translation of Western ideas (in this case, "ethics") when they arrive in new contexts and the differential meanings they are given. Second, it illustrates the sense of purpose bestowed upon certain categories of individuals (in this case, HIV Counselor Trainers), who are charged with the task of advancing the global AIDS agenda in a setting far from its international origins.

This dissertation aims to show that an HIV test is about more than whether one is HIV positive. A single test arouses issues of power and rights; it is a locus of

international and national debates, conflict in health facilities, and contestation between couples. It is a development package, a representation of Western superiority, and an opportunity for social mobility. Ironically, in terms of the industry it has created in poor, high prevalence countries, HIV (testing) may save as many livelihoods through employment as the number of lives it condemns through a positive test result.

This dissertation is about testing differences, and it aims to test several sets of differences: differences between policy and practice; differences in how the rationalities and motivations of various actors affect the implementation of a key global AIDS intervention; and differences in how we know what we know based on our methods of inquiry.

THE DEVELOPMENT OF AN HIV TESTING REGIME

The foundational principles (the "3Cs") upon which HIV Testing rests-- (1) that testing includes *counseling*, (2) that testing be conducted with *informed consent*, and (3) that the test result be *confidential* (UNAIDS/WHO 2004: 1)-- are quite different from the public health strategies for addressing most infectious disease. Efforts to control other sexually transmitted or lethal infectious diseases, such as syphilis or tuberculosis, have traditionally involved far more stringent measures, such as compulsory testing, contact tracing and occasionally even, involuntary quarantine (Obermeyer and Osborn 2007). In contrast, the development of approaches to HIV Testing had its roots in the early history of the AIDS epidemic in Western democracies (notably the United States), where the disease disproportionately affected stigmatized groups – gay men-- and concerns abounded about the use of prevention measures that would ensure that the

epidemic not be driven underground (Bayer et al. 2007; DeCock, Mbori-Ngacha, and Marum 2002).

As HIV was recognized as a pandemic, the "3Cs" were institutionalized globally by the World Health Organization (WHO) and The Joint United Nations Programme on HIV/AIDS (UNAIDS) (International Consultation on AIDS and Human Rights, Global Programme on AIDS (World Health Organization), and United Nations Centre for Human Rights 1991; UNAIDS 1997; UNAIDS/WHO 2004). The global justification for the institutionalization of the "3Cs" has two primary foundations: a public health rationale, which reasons that when testing is voluntary and when it includes counseling on HIV prevention, it is more likely to result in behavior change to avoid infection or transmitting it to others; and a concern for the fulfillment of international human rights standards against HIV-related stigma and discrimination. As Bayer and Edington explain:

> Out of the clash between the traditionalist perspective — one that favored routine testing conducted under conventional assumptions of presumed consent — and the viewpoints of those most at risk for the new disease would emerge a set of testing policies that stressed the importance of *voluntarism*, which underscored the centrality of *counseling* and embraced *confidentiality* as a prerequisite for effective programs (CDC 1986). *It was in this context that those who began to speak in the name of ethics and human rights sought to provide guidance, using language that would have a lasting impact on the international discourse on testing.* (Bayer and Edington 2009:302) [Italics added by author]

The prominence of human rights in the discourse on HIV/AIDS sets it apart from other diseases, and is attributed largely to the late Jonathan Mann, founding director of the Global Programme on AIDS (GPA) at the World Health Organization (Altman 1999). While many observers have noted the positive potential of placing HIV/AIDS in

a human rights context (Gruskin, Mills, and Tarantola 2007; Mann and Tarantola 1998), others have questioned the focus on individual rights as an effective public health strategy (DeCock, Mbori-Ngacha, and Marum 2002), particularly outside of Western democracies (Scheper-Hughes 1994). Nonetheless, these testing norms were adopted by many national governments, where they were implemented in contexts like many countries throughout sub-Saharan Africa (SSA) that are decidedly different from the West in the epidemiology of the disease, health infrastructure, and community norms and practices.

Fundamental differences between the West and SSA form the basis of this inquiry as to what happens to imported models when they are incorporated outside of their context of origin. With respect to addressing the AIDS epidemic, several studies have indeed questioned the wisdom of implementing solely Western solutions (Allen 2004; Cleland and Watkins 2006). Most research on HIV Testing in SSA, however, only considers the instrumental and public health efficacy of HIV Testing, emphasizing either the use of testing services, or behavioral change as a consequence of knowing one's HIV status (see Obermeyer and Osborn 2007 for an overview; Sherr et al. 2007 for Zimbabwe; Thornton 2008 for Malawi, for examples). Most studies of testing in practice in SSA also only consider the perspectives of one group of actors who inform the HIV Testing encounter -- either the testing experiences of ordinary people (see Sangiwa et al. 2000) or of those who provide HIV Testing services (see Grinstead and Van Der Straten 2000; Paoli, Manongi and Klepp 2002).

A rigorous, sociologically-informed analysis of HIV Testing, however, ought to accomplish more than evaluation and offer more than a single set of perspectives. Towards that end, this dissertation takes a fundamentally different approach. It aims to illustrate the differential incorporation of HIV Testing's "3Cs" in a setting far from its international origins through an in-depth examination of how it is advocated by its champions, adapted by its implementers, and received by its beneficiaries.

HIV/AIDS IN SUB-SAHARAN AFRICA: THE GLOBAL RESPONSE

As everyone now knows, AIDS is an incurable disease affecting populations worldwide. Sub-Saharan Africa remains the most heavily affected region, "accounting for 67% of all people living with HIV and for 72% of AIDS deaths in 2007" (UNAIDS 2008:5). The devastation caused by AIDS in Africa has captured the world's attention, producing an unprecedented global response. HIV/AIDS spending has outnumbered that of other development projects and life-threatening diseases: for example, whereas in 1992 HIV/AIDS received 7.7% of all donor health and population aid, by 2003, it received more than one-third (35.1%) (Shiffman 2008). HIV/AIDS has led to the generation, proliferation and expansion of numerous organizations, from international bodies such as UNAIDS and funding agencies such as The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), to non-profit church and missionary organizations such as the Catholic AIDS Alliance and World Vision who have joined the fight against AIDS (Swidler 2006). HIV/AIDS has also created the emergence of an entire industry complete with new experts, all focused on a "single disease" (Morfit forthcoming: 4).

International donors (both multilateral and bilateral) have responded generously in supporting interventions to prevent the onward transmission of HIV, and to allay the impact of AIDS in low-income countries suffering from a generalized AIDS epidemic. Notably, the Global Fund, a multilateral financing institution established in Geneva in 2002 and administered by the World Bank, had approved HIV proposals totaling close to US$10.8 billion by the end of December 2009, and one-fifth of all disbursements went to low and middle-income countries (The Global Fund to Fight AIDS Tuberculosis and Malaria 2010). In 2003, the United States committed $15 billion to establish the President's Emergency Plan for AIDS Relief (PEPFAR), the largest bilateral effort against AIDS in resource-constrained countries. HIV Counseling and Testing-- both as a prevention measure and as a purported "gateway" to antiretroviral treatment-- has been among the prevention efforts receiving the most support and attention in the global AIDS community (UNAIDS 2002). As declared by Kevin De Cock, director of the WHO Department of HIV/AIDS: "…universal voluntary knowledge of HIV serostatus should be a prevention goal…facilitation of HIV testing is central to responding effectively to the epidemic in Africa" (De Cock, Marum, and Mbori-Ngacha 2003: 1847).

MALAWI: AN AFRICA CASE STUDY

Malawi is a small, densely populated sub-Saharan African country of approximately 13 million people. It is land-locked, bordered by Tanzania to the North, Zambia to the West, and Mozambique to the East and South. In many ways, Malawi is an ideal African site to observe the implementation of Western HIV Testing norms in a

very different setting: it is extremely poor, with the majority of its population surviving on less than $2 a day (The World Bank 2008); it suffers from a severe AIDS epidemic that affects the general population, not just particular high risk groups[1]; and especially in rural areas, where 80% of its population resides, Western-oriented discourses about human rights are relatively new (Englund 2006).

Figure 1.1. Map of Malawi in the African Continent

In Malawi, national efforts to address the further spread of HIV began in 1985 when the first AIDS case was reported and the government subsequently adopted a blood screening policy. In 1989 the National AIDS Control Programme (NACP) was established within the Ministry of Health and Population; throughout the 1990s, District

[1] A generalized epidemic means transmission occurs mainly through heterosexual sex or from mothers to their babies during pregnancy, labor delivery or breast-feeding. National prevalence in Malawi is estimated at 12% (National Statistical Office [Malawi] and ORC Macro 2005).

AIDS Coordinators and committees were set up throughout the country as part of the government's larger decentralization efforts. In 2001 the National AIDS Commission (NAC) was established by donor demand to replace the NACP and to take HIV/AIDS out of the health sector (Garbus 2003).[2] Among the NAC's mandates was to coordinate a multi-sectoral implementation of Malawi's Strategic Framework for addressing HIV/AIDS. With financial and technical support from USAID and UNAIDS, the National Strategic Plan (2003) identified priority areas for addressing the epidemic in Malawi, including a massive scale-up of prevention programs, of which HIV Counseling and Testing became a central part (Office of the President and the Cabinet and National AIDS Commission 2003). The NAC adopted the guidelines of informed consent, confidentiality and counseling of the WHO and UNAIDS into its HIV Testing programs (Garbus 2003), which to this day remain the "guiding principles" of all HIV Testing policies and initiatives (Ministry of Health [Malawi] 2004; Ministry of Health [Malawi] 2006b).

Malawi's health facilities, the site of the formal HIV Testing encounter, are poor and understaffed. Drugs are scarce, people sick and in need of care, and the hospital waiting areas congested with human traffic. On every visit I made to a rural health facility over the course of three years of fieldwork, all were bustling in the morning, virtually empty in the afternoon, and closed Saturdays, Sundays and national holidays. On a particularly sobering day of fieldwork, the cynic in me wondered if it were possible that Malawians simply don't get sick on weekends and holidays. Consequently, to

[2] NACs were established throughout the African region during this time (Putzel 2004).

minimize the burden that HIV/AIDS has placed on the health care system, NGOs providing voluntary testing ("VCT") and other HIV-related services (also known as "free-standing" clinics) were established throughout the region with the support of Western donors.[3] These services usually provide for what is referred to as the "worried well," those who want to know their HIV serotatus but who are otherwise at low risk for infection.

Testing services first became available in Malawi in the mid-1990s, though they were not widely accessible. In 2004 and 2005, the Malawi Ministry of Health (MOH) received support from the Global Fund to expand the availability of free HIV Testing to all district hospitals, as well as many rural hospitals and clinics. By the end of 2004 there were 146 sites in the public sector, CHAM institutions and the NGO sector providing services for HIV counseling and testing; by the end of 2005, that number nearly doubled (Ministry of Health [Malawi] 2006b). During the rapid expansion of testing services, antiretroviral treatment (ART) also became available in district hospitals for those diagnosed with AIDS and who met the eligibility criteria. Most central and district hospitals in Malawi have a CD4 count machine to determine ART eligibility, but it is said that they often are broken or the lab technician is absent. Thus, it seems that ART eligibility is usually determined by clinical staging standards developed by the WHO: on

[3] Malawi AIDS Counselling and Resource Organization (MACRO), Malawi's largest NGO providing voluntary HIV counseling and testing services throughout the country, was established in 1995 with support from USAID, ActionAid, UNAIDS, and the U.S. Centers for Disease Control (CDC). Before that time, only two sites in the country offered voluntary testing services and were run by the government through the NACP.

a 1-4 scale, those exhibiting AIDS-related symptoms staged at a 3 or 4 are recommended for treatment (Ministry of Health [Malawi] 2007b).

The expansion of testing services required increasing the number of trained health personnel to implement the testing. In effect, this meant recruiting a national cadre of nonmedical health personnel to implement the testing, one category of which were Health Surveillance Assistants (HSA), personnel who are assigned to deal with general community health needs such as sanitation and the distribution of bed nets. In 2004, the 146 testing sites had 711 HIV Counselors; by the end of 2005, the total number of trained and certified HIV Counselors reached 1,136. Also by the end of 2005, 50 HIV Counselors were trained as "Trainers" of new counselors, and 87 Counseling and Testing senior personnel from District Health Offices and the NGO sector were certified as "Counseling and Testing (CT) Supervisors"(Ministry of Health [Malawi] 2006b).

The expansion of testing services, treatment availability, and the health workers to implement the services was accompanied by the development of several related policy documents. In 2004, and with assistance from the Centers for Disease Control (CDC), the Ministry of Health produced a set of HIV/AIDS Counseling and Testing Guidelines, the document in which the "3Cs" are contained, with the aim of standardizing the basic minimum requirements for "establishing, providing and monitoring CT services in Malawi" (Ministry of Health [Malawi] 2004: ii).[4] A national HIV Counselor training

[4] The first counseling and testing guidelines in Malawi were developed in 1992 by the National AIDS Control Programme (NACP) of the Ministry of Health. Every official with whom I met in Malawi, however, was unable to locate the document and referred only to the second edition, developed in 2004.

curriculum was also developed in 2004, and revised in 2007 when HIV Counselors started handling the drawing of blood for rapid HIV tests.[5] In 2007, the Ministry of Health also reduced the HIV Counselor training course from 5 weeks to 3 weeks, as 5 weeks was deemed too time consuming and costly.

In line with changes in international standards set by the WHO and UNAIDS, in 2006, the Ministry of Health replaced the "V" ("voluntary") from the long-standing "VCT" acronym ("Voluntary Counseling and Testing") with an "H" for "HTC" ("HIV Testing and Counseling"), signaling that HIV Testing would be routine at antenatal visits and for diagnostic purposes (Ministry of Health [Malawi] 2006a; UNAIDS/WHO 2004).[6] Thus, several models of HIV Testing now exist in Malawi, including the traditional client-initiated model of "VCT," and provider- initiated models of "DCT" (Diagnostic Counseling and Testing) and "RCT" (Routine Counseling and Testing). "DCT" and "RCT" are also often referred to as provider-initiated testing ("PITC"), "routine testing" or "opt-out" testing.[7] Despite these changes to the institutional and therapeutic context for testing, however, the "3Cs" (consent, confidentiality and counseling) remain a fundamental component of testing programs. For example, although antenatal and diagnostic testing for HIV is now part of routine practice, in principle patients must still provide informed consent before being tested (Ministry of Health [Malawi] 2007b). Nonetheless, it bears mentioning that while the human rights

[5] Before the integration of the HIV counseling and testing process, clients were sent by the HIV Counselor to have their blood drawn by a lab technician or another certified health worker. With the integration, HIV Counselors counsel clients, draw their blood, and give them their test results.
[6] The acronyms "VCT" and "HTC" are used interchangeably throughout this dissertation, namely because at the time of fieldwork, the change was new and informants (namely villagers) still typically refer to testing as "VCT."
[7] I also use these terms interchangeably throughout this dissertation.

principles that have long-guided testing programs remain, opt-out testing has sparked heated debates in the global AIDS community, ones that have pitted public health traditionalists against human rights activists (Bayer and Edington 2009). The concerns among human rights activists hinge largely on the process of obtaining consent (e.g., should clients be offered a test, with the option to accept; or should they be told that they will be tested, with the option to refuse) and how much pre-test counseling is considered sufficient for a patient/client to make a truly informed decision about testing (UNAIDS Reference Group on HIV and Human Rights 2007).

LITERATURE REVIEW

This dissertation draws from, and builds upon, literature in several fields, including sociology, anthropology and public health. It contributes to scholarship through an in-depth analysis of the relational settings in which global policies-- and the norms that comprise them-- land.

It has been noted widely that AIDS is uniquely a disease of globalization, based on its epidemiology (Barnett and Whiteside 2006), the mobilization against its spread (Swidler 2006), and the dominance of certain discourses in the understanding of the epidemic (Altman 1999; Altman 2001). And while there are several theories on globalization and its effects (Guillen 2000), among the most prominent of perspectives is offered by institutional scholars. John Meyer and his colleagues of the world polity school propose that particular ideas and institutions shape the behavior, structure and identity of nation-states via "worldwide cultural and associational processes" (Meyer et al. 997: 173). This perspective certainly helps explain the global institutionalization of

Western HIV Testing norms (the "3Cs"), which resonate with principles already accepted in the global polity, notably that of human rights (Boli and Thomas 1997). It also helps explain why the "3Cs" were adopted by national governments, who as rational actors, may strive to imitate the modern world and, in fact, face external pressure to do so. Thus, when modern institutions like the "3Cs" are transplanted in the developing world, they have the manifest goal of advancing human rights, but also the "latent effect of serving as symbols of the country's modernity and, hence, relative parity with the developed world" (Portes 2000: 9).[8]

But while the introduction of the "3Cs" throughout countries in sub-Saharan Africa may suggest standardization (or "isomorphism") *on the surface*, world polity institutionalism as a structural theory cannot explain what happens to imported testing norms once they are put into practice and adapted to local circumstances. In short, institutional theories tend to "bracket" what occurs on the ground (Boyle 2002: 6). Rigorous studies of the application of globally-celebrated models in non-Western settings reveal persistent divergences, turning the homogenizing logic of modernization on its head and pointing to the limited utility of the nation-state as a unit of analysis. As Swidler notes, "...the West has been trying to reshape Africa along lines it thought

[8] I use the term "developing" only to the extent that authors which I reference do to signify countries that were referred to formally as "Third World" countries, a term that gained currency during the Cold War to define countries that were neither capitalist (First World) nor communist (Second World) and that were also former colonies. The terms "developed" and "developing" countries emerged in the 1980s when the World Bank redefined "development" as successful participation in the world market (McMichael 2004). I use the term interchangeably with others including "underdeveloped," "low-income" and "resource-constrained," to the extent that they illustrate dependency on foreign aid. The term "West" is also contested, but it has currency in the academic literature. I use it here to signify the cultural influences emerging from Western countries. All of these terms are permeable and fairly dynamic. It is beyond the scope of this dissertation, however, to interrogate their contested meanings in any great depth and detail.

appropriate for centuries, and only some of those efforts at institutional transformation have taken root, often in ways far removed from what their authors imagined (2006: 273).

Thus, in this study, rather than conceiving of HIV Testing as a (value-neutral) public health intervention, I conceptualize it as a dynamic social practice. Towards that end, I use approaches that consider the responses and experiences of those "variously located and affected social actors" who receive -- and redirect -- development projects (Long 2001:15). The approaches that capture the dynamic character of an empirical object of study have several names, including 'actor-oriented approaches' or 'interface analysis' (Long 1999; Long 2001), 'multi-level perspectives' or 'linkages' (van der Geest, Speckmann, and Streefland 1990), 'traveling technologies' (Kaler 2003b), 'social life' or 'biography' (Appadurai 1986), and 'life cycle' (van der Geest, Kinsman, and Hardon 2010). Nonetheless, they are methodologically and theoretically similar insofar as they all have an interest in capturing the "continuously changing character of our objects of study" (van der Geest, Kinsman, and Hardon 2010: 2).

Several notable studies have employed multi-level perspectives, or some conceptual variation thereof, to explore the importation, differential incorporation, and/or local reception that various relevant actors give to imported policies, programs and/or practices. The geographic scope of these studies has been vast, the cast of characters diverse, and the objects of empirical inquiry wide. Nonetheless, the net contribution of these studies is that they all point to externalities—some positive, some

negative, and some neither one way nor the other—that extend beyond the realm of the object(s) of study itself.

Starting at a more macro level, such approaches have been used to study the implementation of *policies* and *programs*, such as decentralization in Latin America (Roberts 2001); international population policies, such as family planning in colonial Zimbabwe (Kaler 2003b) and Tanzania (Richey 2008); and international legislation against female circumcision (Boyle 2002). Smith's study of the implementation of internationally-funded population programs in southeastern Nigeria, for example, shows how it satisfies simultaneously the competing priorities of foreign donors and local participants: donors are able to fulfill their goal of quantifying the number of participants trained in their workshops, while local program participants are able to utilize trainings as instruments of patronage (Smith 2003). Stone's study of the implementation in central Nepal of Primary Health Care (PHC) as articulated in the International Declaration of Alma-Ata, on the other hand, shows that goals are not satisfied equally between international actors and the recipients of their efforts: PHC is organized primarily to provide health education, but Nepalese villagers value curative services and thus perceive little need for new health knowledge (Stone 1986).

Such approaches have also been applied to the study of *organizations*. Swidler, for example, considers the local adaption of organizational models and forms for AIDS governance in sub-Saharan Africa. Her study points to the various, sometimes paradoxical outcomes that emerge when such organizational forms (such as internationally-funded AIDS NGOs promoting voluntarism) interact on the ground with

local patterns of authority and social organization (such as patron-client ties) (Swidler 2006). Hilhorst, on the other hand, takes a different approach to studying organizations: she examines one local NGO in the Philippines in great depth and detail. Her study, as distinguished from the larger body of literature on NGOs, considers NGOs not as *things* but rather as *processes*, thus focusing on the everyday practices and discursive strategies of NGO actors within the organization (Hilhorst 2003).

Finally, such approaches have also been applied to the study of *material items*-- of objects "in motion"-- from modern methods of family planning (Bledsoe, Banja, and Hill 1998; Bledsoe et al. 1994; Johnson-Hanks 2002) including male (Tavory and Swidler 2009) and female (Kaler 2001) condoms, to biomedical drugs (Kinsman forthcoming; Whyte, van der Geest, and Hardon 2002). Kaler's study on contraceptive pills and the Depo-Provera injection in colonial Zimbabwe, for example, illustrates a dual reception: on the one hand, they were seen as technologies of white colonial efforts at population control and thus actively rejected; on the other hand, they were embraced by some African women as a way to assert their bodily autonomy from their husbands and in-laws (Kaler 2003b). Similarly, Johnson-Hanks' study from southern Cameroon shows how women's contraceptive method choice achieves social goals beyond averting pregnancy: the Beti women she studies choose periodic abstinence as means of enacting a modern, disciplined identity (Johnson-Hanks 2002).

As a collective body these studies all implicitly challenge overly structural, top-down theories of social change and point to the varying outcomes that emerge locally in

the wake of external pressure and influence. It is within this tradition that I situate this study of HIV Testing.

Throughout the dissertation I use the terms 'multi-level' and 'actor-oriented' interchangeably since I integrate both conceptually, that is, I consider 'actor perspectives' across 'levels' of social organization. There are three strata of social and institutional actors—operating at different levels of social organization-- whose perspectives and experiences inform this dissertation: the Counseling and Testing Establishment (CTE), HIV Counselors, and rural Malawian men and women. I examine how these actors "operate within the limitations of structural constraints" (Hilhorst 2003: 5) and consider the different outcomes that develop in the ways in which these actors come to terms -- emotionally, rationally and/or organizationally -- with the varying situations they confront (Long 2001).

Differences across the three strata of social and institutional actors considered in this analysis are significant, notably with respect to education, a primary marker of social status in Malawi as well as a primary qualification for jobs. Accordingly, the CTE is a cross-section of representatives from Western donor organizations, Malawian government entities and NGOs. The CTE all have at least a university degree, although there are a few who have only a nursing degree, which requires three years of schooling for which they obtain a diploma in midwifery and nursing. Moreover, with the exception of expatriates, these individuals are likely to have been raised in one of Malawi's four cities (Lilongwe, Blantyre, Zomba or Mzuzu), or at least have gone to secondary school there. Thus, they are largely removed from village life. The income among the CTE is

more or less secure: even if one project ends and they are temporarily unemployed, they are likely to get another job. And, even if the AIDS industry becomes a less significant source of employment, there will likely be other projects that need elites who can write reports, training manuals and guidelines.

HIV Counselors, by contrast, must only have completed Form 4, the equivalent of a secondary school education. In some cases, individuals with a Junior Certificate of Education (Form 2 graduate) are considered for training. HIV Counselors are elite relative to the villagers, but have considerably less status than the CTE, and their jobs and incomes are less secure. If the demand for HIV Counselors diminishes, they would have to seek training for something else, unless they already have another job in the health sector, such as a Nurse. Thus, it is particularly important for HIV Counselors to distinguish themselves from the villagers, which they are able to do through the certificate their training affords them and in their acquired knowledge of Western biomedical jargon.[9]

Finally, most of Malawi's villagers have less than a Form 4 education, no participation in the formal labor market, and no salary at all. Per capita income in Malawi is approximately 25,000 kwacha (about $170 USD), and even less so in the rural areas. Villagers' livelihoods are insecure, often tied to the vagaries of the weather (such as droughts) and fertilizer subsidies provided by the government. Many villagers are so poor that the additional food rations for being HIV positive distributed by health facilities with the support of Western donors can be a tremendous help, while the cost of

[9] See Swidler and Watkins 2009 for a discussion of Malawi's "interstitial," "aspiring" elites.

transport to the nearest facility for getting and refilling ART is a serious expense, even if it is as little as 100 kwacha (about .70 cents).

It is important to note from the outset, however, that there is significant heterogeneity *within* the groups I study. For example, as previously mentioned, the CTE is comprised of individuals from Western donor organizations, government entities and NGOs, and includes both expatriates and Malawian nationals. HIV Counselors vary in terms of demographics (e.g., age, gender), their work sites (e.g., district hospitals, rural public clinics, free-standing testing sites), and the additional roles they occupy as health workers (e.g., Nurses, Health Surveillance Assistants). Rural Malawian men and women also vary in terms of socio-demographic characteristics (e.g., age, gender, marital status, social status, religion). It is beyond the scope of this dissertation to consider differences *within* each category at great length, though I am mindful of their importance and thus tend to them when appropriate in my interpretation of the data.

RESEARCH METHODS

A rich combination of qualitative data allow me to link HIV Counseling and Testing (the "3Cs") -- a program with Western origins and emanating from the global AIDS community – with a detailed examination of its local, differential incorporation in sub-Saharan Africa. This study is based on fieldwork I carried out over the course of three years (8 cumulative months)[10] in Malawi, primarily in Lilongwe, Malawi's capital city, and several rural districts, namely Mchinji (Central Region) and Balaka (Southern

[10] Research funding was provided by a University of Texas Liberal Arts Graduate Research Fellowship (2007), a Doug Forbes Dissertation Award (2008), a QUEST Travel Award (2009), and a Dissertation Improvement Grant from the National Science Foundation (2008-2009).

Region).[11] I draw upon and integrate strategically various qualitative sources: 1) several hundred hours of participant observation; 2) focus group discussions with rural Malawian men and women; 3) interviews and informal conversations with international and national elites, Village Headmen, HIV Counselors, and rural Malawian men and women; and 4) a unique set of field journals that capture local experiences with HIV Testing.[12]

Figure 1.2. Map of Malawi and Primary Study Sites

[11] Mchinji (Center) and Balaka (South) have notable cultural differences. The primary ethnic group in the South are Yaos, who are Muslim; the primary ethnic group in Mchinji are Chewas, who are Christian.
[12] A sample of the observational field journals are available online at: http://www.malawi.pop.upenn.edu.

I first entered the field in the summer of 2006. I was hired as a graduate research assistant with the Malawi Diffusion and Ideational Change Project (MDICP), a longitudinal household panel study on HIV/AIDS and social networks based at the University of Pennsylvania with which the University of Texas at Austin is affiliated.[13] I arrived unaware of what was expected of me but like most projects of its kind, there was never a paucity of work to be done. I took on the task of supervising data collection for the HIV home-testing component of the research study in the Southern region of Malawi (Balaka, one of the larger project's three sites), which involved collecting HIV biomarker, survey and qualitative data from approximately 1,000 sample respondents in that area.

The inspiration for this dissertation project came to me during the most unlikely of moments: the field training of the MDICP HIV Counselors. As a former HIV Counselor with the Gay Health Advocacy Project at Columbia University Health Services, where I worked for 2 years while pursuing my Masters degree, I was struck by the similarities (and at times differences) between the training of our Malawian field staff and my own training. The protocol for HIV Testing with respect to seeking informed consent, for example, and the importance placed on pre- and post-testing counseling in both contexts were remarkably similar. Yet the details were decidedly different. The emphasis in the Malawian training placed on prayer during the counseling process as a way to help clients deal with a positive diagnosis, for instance, struck me not only as unique perhaps to the African context, but antithetical to Western (i.e.,

[13] Malawi Diffusion and Ideational Change Project (PIs Susan Watkins, Hans Peter Kohler and Jere Behrman). See http://www.malawi.upenn.pop.edu for a description of the project.

secular) counseling. So too did the idea of testing married couples, since in the context where I was trained, HIV was understood as an epidemic primarily affecting particular high-risk groups, namely gay men and injecting drug users.

Over the course of two months, I had access to several moments that, in retrospect, were a perfect pilot for a Ph.D. dissertation: the observations of the training of our team of HIV Counselors, who would administer door-to-door HIV Testing in our project villages, and the daily opportunities to chat informally with our project HIV Counselors while returning from the field, on group jogs in the evening, and over meals. I left the field that year with research questions that would preoccupy me in the years that followed: if, from what I learned in my own training, HIV Testing developed in such a way to protect gay men from the further stigma of being HIV positive, how did this type of testing make its way from the West to sub-Saharan Africa?; and, how might it chang in practice and most importantly, why?[14]

Participant Observation

My fieldwork—like my empirical object of study—is also in transit: it moves iteratively from international headquarters, to government ministries, to clinics, to villages where the targets of testing programs reside. It is guided by that which is placed on paper in Geneva (the site of the WHO and UNAIDS) and in the capital city of Lilongwe, and that which is put into practice in rural health settings far from its international origins. My fieldwork was complemented, enhanced, and made significantly more enjoyable by the invaluable collaboration of Kondwani Chavula, who

[14] I do not pursue the first research question in this dissertation. It is nonetheless a question of theoretical and empirical import for future inquiry.

is Malawian, male and 30 years old. Kondwani's observations and field notes inform this analysis.

Throughout the course of fieldwork, I sat with HIV Counselors as they were trained. I watched people get counseled and tested for HIV and sit in packed spaces waiting patiently for their medication. I ate with expats in their affluent, gated homes, as Malawian women carried their children on their own backs while they poured our afternoon tea. I attended the National AIDS Commission annual meetings, where elites schmoozed over hot lunches, boasting about their recent donor meetings overseas. In my own attempts to better understand the great distance involved in reaching a health facility, I embarked on a combination of walking, hitchhiking and taking mini-buses. I sat in the back of pick-up trucks with young mothers with their children in tote trying to access care, as well as in health facilities where the patient flow went from hundreds to zero, as people in need of care waited to be seen by a health provider but never were.

Despite the number of months I devoted to the field, I call this work an "imperfect ethnography," a term I adapt from Nancy Scheper-Hughes. In her masterful book, *Death without Weeping: The Violence of Everyday Life in Brazil*, Scheper-Hughes refers to her work as a "good enough" ethnography, a term she fashions in response to the post-modern critiques of ethnography as ill-natured and exploitative of the "other" and that recognizes the ethnographer as a cultural being who is "necessarily flawed and biased" (1992: 28). During the course of fieldwork, I also suffered from the concerns raised by post-modern critics. I found it hard to shake the feeling that my ultimate success as a Ph.D. would depend on the generosity of others' time, their willingness to

speak, to be observed as I took notes, their trust in my motivations to learn. In my hardest moments, I felt I had nothing to offer in return but things that felt insignificant to me: some Barack Obama election paraphernalia, a ride when solicited, a soda or meal, some extra malarial medications or aspirin, an offer to courier a gift to someone in the U.S. or information on overseas scholarships.

But throughout the course of fieldwork, I discovered that perhaps I had minimized how much my informants valued the opportunity to be heard. Indeed, as Scheper-Hughes notes, "not to look, not to touch, not to record, can be the hostile act, the act of indifference and of turning away" (1992: 28). One rural Malawian man, for example, told Kondwani before the start of a focus group discussion that he would like to have their tape-recorded conversation broadcast on the radio. In a far-flung health facility, one I opted to walk to for a field visit to better understand the long distances involved in accessing care, I called an HIV Counselor who was expecting me to apologize and let him know I'd be arriving late. He told me how disappointed his fellow counselors would be if I did not make it and insisted I make every effort to hitchhike for a ride. I was also invited by some members of the CTE to return to work for their organizations, teach at Malawi's College of Medicine in Blantyre, and assist as an external evaluator of their HIV testing campaigns. This is not to suggest however that I, nor my interests in the setting, were always received openly. Though it is rare in this research setting to turn away a "stranger" (Weinreb 2006), many do find their own ways (Angotti et al. 2009). In interviews, for example, a few individuals asked that particular points made not be noted; others simply were unavailable at the time I had come to visit

their worksites. Interestingly, concern was biggest among the CTE, and a couple of individuals asked that they not represent their organizations or that certain comments made not be noted. These concerns were never an issue at "lower levels" of analysis (Kinsman forthcoming).

My work is "imperfect" in several ways. Given the various strata of individuals I was studying, I was unable to live and observe in great depth the quotidian lives of all of them. When I was working in rural areas, I stayed in lodges close to the trading centers; while in urban areas, I stayed in the homes of expats or with those who were part of my research team. But this also meant I was exposed to striking juxtapositions—between rich and poor; urban and rural; those who are educated and those who are not—rendering the task of "testing differences" all the more salient.

Since I was unable to live with those whom I was studying, witnessing for example how the decision was reached to take an HIV test, nor accompany them to the clinic for a test or back home afterwards, my understanding of the testing encounter is informed in the following ways: a single moment observed in "real time and space" (e.g., observations of the HIV Testing process) (Auyero and Swistun 2008: 374), as well as retrospective and second-hand accounts (e.g., interviews with individuals tested for HIV and observational field journals). I am also not fluent in Chichewa, Malawi's *lingua franca*. I did, however, study Chichewa formally and informally while in Malawi and tried my best to learn all standard greetings, words and expressions associated with my research so that I could engage in some local banter, place an order for nsima (Malawi's staple dish), and convey an interest in where I was. Consequently, it meant that data

collected in Chichewa had to be done by research assistants and translated into English. My research assistants, however, worked very closely with me throughout the fieldwork process and were trained extensively in this project before it began.

The very nature of this project, that of garnering several perspectives across different levels of social organization, invariably meant that responses to my positionality as a white, female, Western researcher was variously received. As an extremely poor country, and one heavily dependent on Western donor aid, azungus[15] are increasingly part of the social landscape in Malawi. Consequently, my presence, though ostensibly openly received, might have been perceived with mistrust or suspicion, but perhaps also with a sense of hope. National elites, who are directly exposed to Western interpretations of Africa (Tawfik and Watkins 2007), rarely spoke outside of official discourse about HIV Testing and the practices that comprise it, though they did express areas where they thought improvement was needed. Western expats, on the other hand, often engaged with me tacitly, laughing about idiosyncratic Malawian ways of doing things or using the West as a reference to which we both could relate. HIV Counselors spoke of their jobs with a missionary zeal, as an opportunity to help others. They communicated their sense of identity as "modern" individuals who, as distinguished from villagers, are well versed in Western biomedical language. They also complained about poor salaries and lack of recognition, perhaps with the expectation that I would share their complaints with the proverbial "powers that be" or recommend them for a better paying job. And though I did not interview them myself, villagers knew that the

[15] *Azungu* is a term used locally to refer to Caucasians, whites of European descent.

interviewers were working for a mzungu, so comments were also made about problems in their villages, such as the need for support in providing new boreholes or health facilities within closer reach, or their own need for a child's school fees.[16]

To minimize the potential for these methodological biases, I reminded my interlocutors (and had my research assistants do that same) that I am not a donor, nor am I conducting a program evaluation. Rather, I am a student from America working on a dissertation on HIV Testing and interested in learning more about their perspectives and experiences with the process. Reactions to my positionality, however, to the extent that I was able to observe them, were informative in and of themselves. I was in the field to study how imported practices are received and transformed in the process of their implementation. I was also, in a way, imported, and individuals doubtless responded to my embodiment as a Westerner. Those differential responses lent important insight into how Western practices are viewed with some suspicion, embraced, and even assumed to be legitimate, given their origin.

Interviews

Interviews were conducted with members of the Counseling and Testing Establishment (CTE), HIV Counselors, Village Headmen, and rural Malawian men and women (clients) tested for HIV.[17] All interview protocols were developed to elicit perspectives on consent, confidentiality and counseling (the "3Cs"), though the approach taken for each group necessarily differed, which I explain in further detail in the

[16] For expectations of material benefit from outsiders, see Hannan (2010).
[17] Interviews with individuals tested for HIV were conducted as a qualitative follow-up to a larger study on testing and treatment surveillance led by the University of Pennsylvania in conjunction with the Malawi Ministry of Health.

empirical chapters (Chapters 2, 3 and 4). Interviews lasted between 30 minutes to just over an hour. Interviews with members of the CTE and HIV Counselors took place in English, the colonial and official language of Malawi; interviews with Village Headmen and clients took place in Chichewa. The interviews were not tape-recorded (except for those with the HIV-tested sample). Rather detailed notes were taken, which were transcribed within a day of the interview itself. I add quotations in the interview passages utilized in the empirical chapters (Chapters 2, 3 and 4), though these are not the direct speech of my informants. I have tried to retain my informants' communications as precisely as possible.

Counseling and Testing Establishment (CTE). I conducted 20 interviews with the Counseling and Testing Establishment, a cross-section of representatives from Western donor organizations, Malawian government entities, and non-governmental organizations (NGOs). I gathered the names of those individuals listed as contributors to the HIV counseling and testing documents central to this analysis: HIV Counseling and Testing Guidelines, HIV Counselor Training Manuals, HIV Counseling and Testing Scale-Up Plans, as well as members of the "HTC Working Group."[18] I also included two individuals whose names appeared prominently in Malawian newspapers as official spokespersons for HIV Testing. This was a largely self-referential group, however: when I asked informants if there were others with whom they thought I should speak, the same

[18] The HIV Testing and Counseling (HTC) Working Group is compromised of various "stakeholders," including representatives from donor organizations, government ministries, and NGOs. The Working Group, of which there are others in Malawi as it relates to HIV/AIDS (e.g., ART Working Group), meets every few months and contributes to and reviews Malawi's policy documents and programs for its related area.

names invariably came up. The interviews took place namely at work sites (13), and on occasion, at coffee shops/restaurants (4), homes (1), and over the phone/Skype (2). Unless out of town, I was always accommodated, meeting some informants over lunch breaks, after working hours, or even on weekends.

Table 1.1. Sample Characteristics: The Counseling and Testing Establishment

	Count	**Percent**
Gender		
Male	9	45%
Female	11	55%
Nationality		
Expatriate	5	25%
Malawian	15	75%
Type of Organization		
Government Entity*	5	25%
Non-Governmental Organization (NGO)	13	65%
Donor Organization	2	10%

TOTAL 20
Average age: 41

*Though most of the donor funding for AIDS is channeled through the National AIDS Commission (NAC), the NAC is considered here to be a government entity, not a donor.

HIV Counselors.[19] I conducted 29 interviews with HIV Counselors throughout several rural health facilities offering HIV Counseling and Testing services. These facilities included government district hospitals, Catholic mission hospitals/clinics, free-

[19] I use the term "HIV Counselors," though counselors are referred to typically as "VCT Counselors" (Voluntary Counseling and Testing Counselors) or, more recently, "HTC Counselors" (HIV Testing and Counseling Counselors).

standing clinics, and local public clinics. Most, though not all, of the counselors were employed at the health centers in other capacities, such as Nurses, Health Surveillance Assistants (HSAs) or Lab Assistants (19); others were employed solely as paid full-time counselors (6); the remainder were volunteer counselors (4). In all cases, the counselors were selected to be trained because they demonstrated good performance in a previous job, because of a dearth of available health workers to serve solely as HIV Counselors, or patronage, that is, someone they knew had helped them get the training and/or job. Of the 29 total interviews, all but three took place in a room at the health facility itself; the other two took place at the lodge where I was staying and one at a restaurant in the trading center.

Table 1.2. Sample Characteristics: HIV Counselors

	Count	**Percent**
Gender		
Male	15	52%
Female	14	48%
Position		
Paid	25	86%
Volunteer	4	14%
Type of Facility		
Government District Hospital	7	24%
Catholic Mission Hospital	7	24%
Free-standing facility (NGO)	3	10%
Local public clinic	11	38%
Military Hospital	1	3%

TOTAL: 29
Age: Average: 34; Range: 20-50 years old
Year trained: Range 2001-2007; Modal range: 2005-2007

Village Headmen. The majority of Malawi's population lives in rural areas, where, like elsewhere in sub-Saharan Africa, chieftaincy is an important institution in the provision of public goods and services (Dionne 2010: 80). In rural Malawi, the Traditional Authority is the highest form of local authority, followed by the Group Village Headman, and then the Village Headman. The decision to include headmen as important actors in this study occurred inductively: in the process of conducting fieldwork at a rural district hospital, an ARV clerk explained to me that they appeal to headmen to help them locate HIV positive individuals who have not returned to the hospital for their antiretroviral medication. Thus, in this study, Village Headmen were asked to discuss their involvement and perspectives as it regards HIV Testing in their villages. Fifteen interviews were conducted with Village Headmen throughout several Malawian villages, usually outside the headman's home.

Table 1.3. Sample Characteristics: Village Headmen

	Count	**Percent**
Gender		
Male	13	87%
Female	2	13%

TOTAL: 15
Age range: 23-93[20]

Clients. Thirty interviews with local Malawian men and women tested for HIV were conducted as a qualitative follow-up study to a larger study on HIV testing and treatment surveillance led by the University of Pennsylvania in conjunction with the

[20] Dionne's (2010) study on village headmen in rural Malawi—which takes place in the same research sites as this study-- finds that headmen span a broad age range of 23-93.

District Office of the Ministry of Health in Mchinji District.[21] The sample of respondents was drawn from the population of attendees undergoing HIV Testing in November and December 2006 at the two hospitals in the district and one government-run clinic. The sample was restricted to respondents over 18 years of age with complete identifying information from the clinic survey, which includes name, gender, residence and age.

The interviews were conducted privately in respondents' homes or, very occasionally, in a location of the respondent's choosing. The interviewers asked about personal and family health, experience with HIV Testing, knowledge about antiretroviral treatment, and local health services. The interviewers were trained to probe or revisit questions when respondents gave short answers, conflicting statements, or used advocacy language (e.g., "It's important to know your status;" "I wanted to plan for the future"). The interview transcripts were typed in the field, providing an opportunity to follow-up with the interviewers about any exchanges or English words that were unclear in the translations.[22]

[21] The study received ethical approval from the Institutional Review Board at the University of Pennsylvania and the Malawi Ministry of Health National Health Sciences Research Committee (NHSRC).
[22] For full methodological details about this study see Angotti, Dionne, and Gaydosh 2010.

Table 1.4. Sample Characteristics: HIV-Tested Clients (Villagers)

	Count	Percent
Gender		
Male	7	23%
Female	23	77%
Marital Status		
Married	24	80%
Divorced/Separated	3	10%
Widowed	1	3%
Single	2	6%
HIV Status		
Positive	14	47%
Negative	16	53%
Why tested*		
Antenatal	13	43%
Sick	10	33%
To know status**	7	23%
On ART		
Yes	3	21%
No	11	79%

TOTAL: 30
Average age of respondents: 26
Age range: 18-42

*In a few cases, the "why tested" responses overlap, such as respondents who note that they were getting sick often and concerned about an infidel spouse. The primary reason the respondent stated for getting tested was the one tallied.
**Responses in the category "to know status" varied, though the overwhelming majority were either concerned about their partners' HIV status (e.g., a husband who takes a co-wife; a distant relationship; concerns about infidelity) or about the cause of sickness in their family.

Focus Group Discussions

I conducted five focus groups, each with five to eight respondents: three groups had men and women; one group only women; and one group only men. The focus groups lasted between 40 and 60 minutes. Local Malawian men and women were

recruited for voluntary participation in one of two ways: either the Village Headman helped my field assistants locate members of his village, or the field assistants approached individuals already congregating in open settings-- such as a group of women seated on a veranda braiding each others' hair or a group of men playing cards outside a local grocer.

The field assistants presented village locals with a series of vignettes about the HIV Counseling and Testing process. One vignette, for example, which aimed to tap how villagers perceive the process of consent, posed the following scenario: "Lucy is pregnant and goes for antenatal services for the first time. When she goes to the antenatal clinic, what do you think will happen?" Throughout the discussion, the field assistants interjected as appropriate with related questions such as: "What if Lucy refuses the HIV test?" or "What if her husband does not want her to be tested?" Focus group discussions were conducted in Chichewa by Malawian research assistants and translated and transcribed into English by their respective facilitator. Like the client transcripts, focus groups transcripts were also typed in the field so that any exchanges or English words that were unclear in the translations could be clarified.

Observational Field Journals

I also integrate into the analysis a unique set of field journals, kept by Malawian field assistants, which capture local experiences with HIV Testing in the form of ethnographic texts.[23] The journals are part of a larger project in Malawi that began over a decade ago, and aims to learn what people say about AIDS when they are talking with each other in informal conversations in natural and public settings (see Watkins and Swidler 2009). The journals are written in English and use parentheses or carets (< >) to bracket explanatory comments or expressions that are untranslatable in local languages, Chichewa or Yao. The field assistant whose journals I utilize here is also a HIV Counselor and the entries analyzed come from his experience-- and at times, his reports of his colleagues' experience-- with HIV Counseling and Testing. I analyzed ten journals, each averaging 30 pages in length.

The journal method, as with participant observation, offers a perspective that is more immediate and thus closer to actual practice than retrospective reports in a formal interview or hypothetical situations posed in a focus group. They allow one to overhear-- albeit at second-hand-- the informal conversations between and among HIV Counselors, clients, their families and other health workers, in effect offering a more dynamic picture of the HIV Counseling and Testing process, specifically the point at which counselors and clients interact. For the field assistant, the journal writing task is an exercise in

[23] Examples of the journals are available publicly at www.malawi.pop.upenn.edu. Ethical approvals for the MDICP, which included the collection of journals, was given by the Institutional Review Board at the University of Pennsylvania and, in Malawi, initially by the Institutional Review Board at the College of Medicine, University of Malawi, and subsequently by the Institutional Review Board at the National Health Sciences Research Committee.

reflection, since it does not elicit an immediate response in the same way that a probing interview question would. This has the advantage of permitting the field assistant to illustrate the process of HIV Testing in greater detail and depth, as well as a corresponding disadvantage (from a methodological perspective) of allowing more time to edit words with the reader in mind.

Archival Analysis

To substantiate arguments made throughout the analysis, I also integrate variously those articles on HIV Testing from one of Malawi's leading national newspapers, *The Nation*. Kondwani and I made several trips to the archives, located in Blantyre, Malawi's second largest city. With the assistance of their archivist, we were given access to all articles on HIV Testing from 1998-2009. We digitally photographed (.jpg) all the articles and put them on a CD. We then converted the photographs to .pdf, stitched them together into one long .pdf, and ran the "object character recognition" (OCR) program within Adobe Acrobat Professional to identify all text and make the .pdf searchable.

Between 1998 and 2009, I identified 32 articles on HIV Testing, which I found through a text search by the keyword "test."[24] Of all the articles, the overwhelming majority dealt with issues of testing uptake, for example, the success of mobile testing campaigns, gender differences in who is going for testing, and so forth. A non-negligible proportion (n=6) dealt with one "C," consent, such as cases where HIV Testing was perceived locally as mandatory to receive care.

[24] I do not include articles that talked about testing as a visa requirement for certain countries.

Data Analysis

I coded for content interviews, focus groups, ethnographic field notes and observational field journals using qualitative software *NVivo* 8.0. Initial themes, however, were developed throughout the course of fieldwork through extensive, daily memo-writing (Emerson, Fretz, and Shaw 1995). Indeed, as Matthew Desmond notes about fieldwork: "… [it] is never fully inductive or fully deductive but a determined search in which deductive orientations, with loyalties to theory, and inductive orientations, with loyalties to the field, join together in a dialectical fashion" (Desmond forthcoming: 5).

For conceptual organization and to assist with analysis, I created a detailed spreadsheet in MSExcel containing all collected, coded data. I created individual sheets for the interviews with the following actor categories: CTE, HIV Counselors, Village Headmen and Clients; and additional sheets for the following field methods: focus group discussions, observational field journals and archival analysis. In each spreadsheet I created four substantive columns. One column summarized the "story" emanating from the transcript or field note, and the other three columns provided the perspectives on each "C": consent, confidentiality and counseling. I also included columns with demographic information including – where appropriate-- age, gender, job title, work site, etc., so that I could generate relevant descriptive statistics for each group.

In the qualitative accounts offered, I give pseudonyms to all individuals and any names, including the names of health facilities, family members, or other health workers, to which they refer. For the observational field journals, I identify the field

assistant as “Sekou”; in the interest of legibility, I insert clarifying or missing words in brackets and make very minor edits to grammar. Interviews, field notes, focus group discussions and observational field journals are referenced throughout this dissertation as follows:

- Counseling and Testing Establishment interviews: noted by type, interviewee number and year interviewed (e.g., NGO representative_#2, 2007)
- HIV Counselor interviews: pseudonym and year interviewed (e.g., Counselor Mary, 2007)
- Village Headmen interviews: By a letter (e.g., Headman K) and year interviewed (e.g., Headman K, 2007)
- Client interviews: Client interviewee number and year interviewed (e.g., Client_#5, 2007)
- Focus group discussions: sex composition, “fgd,” focus group discussion number and year conducted (e.g., Mixed_fgd_#3, 2007)
- Observational field journals: year, month, and day format (080415)

OVERVIEW OF CHAPTERS

In each empirical chapter of this dissertation, I consider how three different strata of Malawian society affect the implementation of HIV Counseling and Testing’s “3Cs”: the Counseling and Testing Establishment (CTE), who design and develop testing programs (Chapter 2); HIV Counselors, who directly link the efforts of the CTE to its intended beneficiaries (Chapter 3); and villagers, whom HIV Testing is meant to benefit (Chapter 4). Throughout, I consider how competing rationalities, aspirations and

concerns across levels of social organization affect how each group of actors sees the "3Cs": the meanings which they attribute to them, the problems they may create, and their solutions. Each chapter begins with an extended field note, illustrating themes relevant to the chapter. It is followed by a description of the group being considered, the chapter's findings divided by each "C" (consent, confidentiality and counseling, respectively), and a discussion. I bring the empirical chapters together in Chapter 5, discuss the major lessons learned from this dissertation, and offer future projections.

However, it is important to note that though the chapters are divided by level of social organization, HIV Counselors and Malawian villagers inhabit the same social space. As such, the data in those chapters (Chapter 3 and Chapter 4) at times include both voices. The choice as to which chapter in which to include it is based largely on the primary perspective that it illustrates and/or its relevance to the subject/topic being explored.

Chapter 2
Counseling and Testing Establishment: A View from Above

It is 3:00pm, tea break time at the National AIDS Commission (NAC) HIV/AIDS Research and Best Practices Dissemination Meetings. This annual three-day conference, held at the National Hotel in Lilongwe, Malawi's capital city, brings together HIV researchers, practitioners and stakeholders working in Malawi, the expenses for which are paid for largely by the Global Fund and other Western donors. The event, which attracts plenary speakers from Malawi's top ministries, is intended to take stock of Malawi's progress in addressing the HIV epidemic, an opportunity to boast about its successes, and consider the challenges that lie ahead.

At the poolside of the hotel, about 100 delegates, a combination of Malawian elites and Western expatriates, are dressed smartly in an eclectic mix of Western business dress and traditional African clothing. They congregate around the two stations serving coffee, tea and afternoon biscuits, staffed by Malawian men dressed in black suits with white napkins draped in perfect rectangles over their left forearms. Some are alone on their cell phones, to which they grip slavishly and pace in short distances. Others schmooze elbow-to-elbow, holding saucers in their left hand, teacups in their right, nibbling delicately on English shortbreads.

I approach two representatives from the National AIDS Commission chatting with one another by one of the tea stands. One is an elderly gentleman with bushy black hair, dressed in a navy blue suit and a divinity tie; the other is a tall woman in her late

40s, dressed in a black dress suit with red leather half boots and a brightly colored head wrap knotted on the left side of her head. She and the gentleman are engaged in cheerful banter. She is clearly charmed by him, as she throws her body back in a hearty laughter, slapping his forearm with her left hand and waving her index finger in his face with her right.

I introduce myself to them as a graduate student from America interested in learning more about HIV Counseling and Testing in Malawi and inquire about the possibility of scheduling a time to meet. The woman, quite receptive, enthusiastic and accommodating of my request, suggests next week. She then smiles widely, turns to her colleague and says, 'She is a Malawian!', a compliment I earn for my correct pronunciation of her last name upon greeting her. They tell me stories of their kids studying in the U.S. and their various, respective travels to different cities there. The gentleman then says to me of his colleague, 'She'll tell you everything you need to know [about HIV Testing in Malawi].'

My conversations with these representatives from the National AIDS Commission during their high profile conference illustrate several issues central to this chapter: the burgeoning AIDS industry in Malawi; the sophisticated, well-traveled biographies of national elites; the ties of Malawian elites to Western donors; the circles wherein "expert" knowledge about HIV is believed to reside. Moreover, these individuals also make time to accommodate me because the expectation of their jobs is such that they must also meet and greet visitors, despite the everyday demands of their work-related responsibilities (Swidler and Watkins 2009).

In the ever-expanding literature on HIV/AIDS, and on testing specifically, scholarship has been concerned primarily with the use of testing services by its intended beneficiaries (see Obermeyer and Osborn 2007 for an overview), and to a far lesser extent, with the work performed by its implementers (see Angotti 2010 for Malawi; Datye et al. 2006 for India; Whyte, Whyte, and Kyaddondo 2010 for Uganda). But a focus on the individuals who set the national standards for HIV Counseling and Testing is also integral to better understanding what happens – or more precisely, what is meant to happen-- in practice, as well as an indication of how countries respond to global trends and demands.

In this chapter, I begin with a description of the group I call the "Counseling and Testing Establishment" (CTE). Next, I use a combination of official policy documents, interviews with members of the CTE and participant observation to present official discourse on the "3Cs."[25] To forecast that which follows: while this group is committed rhetorically to the Western constructs of consent, confidentiality and counseling ("3Cs"), the majority acknowledge the difficulties they pose for the implementation (and expansion) of HIV Testing. I conclude with a discussion of what these influential individuals see as problems with the implementation of testing and what they believe are the solutions.

[25] As van der Geest, Kinsman, and Hardon (2010) note, for those utilizing a multi-level perspective and find it difficult to study so many people and perspectives, official policy documents have been used as a proxy for elite perspectives. I also utilize media accounts as members of the CTE are typically the ones to represent publically official stances on HIV Testing.

THE COUNSELING AND TESTING ESTABLISHMENT

The CTE is a cross-section of representatives from Western donor organizations, Malawian government entities, and non-governmental organizations (NGOs). These individuals are positioned professionally at the center of international and national networks, and apply (and also, adapt) the "rules" from Geneva to Malawi in the form of national policies, manuals, trainings and guidelines. Though heterogeneous in terms of the entities they represent, the stakeholders that comprise this group are homogenous in ways significant to this analysis: they all are university educated; despite their upbringing, they now live in urban areas--particularly Lilongwe, Malawi's capital city; their cosmopolitan identities are nascent or secure; and, most importantly, they have all contributed and/or continue to contribute to the development of Malawi's official counseling and testing programs and policies by virtue of their professional background, training and/or organizational affiliation. Interestingly, barring representatives from Western donor organizations and expatriates, the majority of those with whom I spoke was formerly employed in the public sector as Nurses, Midwives, or Clinical Officers, before moving to work as a bureaucrat in government or for an NGO (as an HIV Counselor Trainer, for example), positions they described to me in interviews as 'promising,' 'challenging' and/or offering better pay in the AIDS industry. In a car ride to the capital city of Lilongwe one July day, my driver Samuel boasted that his brother-in-law recently started working at World Vision, the national headquarters for which we passed en route: 'NGO work,' he told me, 'is considered good work.'

The heterogeneity among this group, however, masks their actual codependence: global actors depend on national elites to adopt and implement their projects (Boyle 2002; Luke and Watkins 2002), and national elites depend on foreign aid to pay their salaries (Swidler and Watkins 2009). Individuals working for NGOs are also subject to the vagaries of donor interest in their programs and must thus constantly tailor their organizational missions accordingly (Edwards 2002): 90% of NGO funds come from multilateral, bilateral and foundation donors (Hulme and Edwards 1997). Despite the relative economic security of this group as compared to HIV Counselors and villagers (discussed in Chapters 3 and 4, respectively), their livelihoods nonetheless currently depend on a dynamic, complex epidemic of which the promotion of HIV Counseling and Testing is but one (if key) part.[26]

In what follows, I focus on how the CTE talks about the "3Cs," what they see as the problems affecting their implementation, and their solutions. In interviews with these individuals, most took the "3Cs" for granted—as existing, foundational, the backbone for HIV Counseling and Testing. In short, the "3Cs" were simply "there." Significantly, their responses focused largely on new approaches to increasing the uptake of testing (such as with home-based testing, mobile testing campaigns, and routine testing for diagnostic and antenatal purposes), the history of their organizations, and/or the evolution of their own careers. However, when asked if and how the "3Cs" would be

[26] While I do not compare and contrast this group's perspectives in the analysis, an in-depth study interested solely in this group of actors would very likely find variation among them, such as how a representative from one entity (e.g., NGO) feels about the other (e.g., Government) (see Luke and Watkins 2002). For example, a few NGO representatives said the Government took credit for certain successes that they claim were their own, such as mobile testing campaigns; Ministry representatives blamed the NAC when they didn't have the funds to finance certain projects, such as home-based testing.

affected as the national push to expand testing continued, the responses varied: many replied emphatically that the "3Cs" would remain intact; when probed further, most acknowledged and commented on where the problems for the effective implementation of "3Cs" resided and offered what they believe to be the solution(s).

THE "3Cs"

> Providers of CT services will be required to subscribe to an ethical code of conduct consistent with the principles of human rights as outlined in the Malawi Constitution and the Universal Declaration of Human Rights and Professional Ethics. These principles include: the right to privacy, the right to non-discrimination, equal protection and equality before the law, the right to establish a family, the right to the highest attainable standard of physical and mental health, and the *right to informed consent* before a medical procedure. *Every effort should be made to deliver CT services in such a way as to reduce stigma, to guarantee and to protect clients' privacy and confidentiality.* (Ministry of Health [Malawi] 2004: 9-10) [Emphasis added by author]

This passage from the 2004 HIV/AIDS Counseling and Testing Guidelines for Malawi, the document that was developed to "describe and define basic minimum requirements for establishing, providing and monitoring CT services in Malawi" (Ministry of Health [Malawi] 2004: ii), can be seen as a composite statement on the centrality of human rights principles-- the Western constructs of consent, confidentiality and counseling-- in matters of HIV Testing. This document also serves as the Ministry of Health's "policy instrument in guiding establishment, provision and scale-up of CT services in Malawi" (ibid:ii).

But what is written on paper does not—and cannot-- tell us everything about the application of foreign imports. When asked about any difficulties with the implementation of testing with respect to the "3Cs," respondents from the CTE typically

replied, ‘We have a code of ethics from the WHO’ [Government representative_ #3, 2009], ‘weaknesses [in counselor performance] are minimal because of [testing] guidelines’ [NGO representative_#6, 2009], or in like fashion, ‘even in the process of changing [expanding and making testing services part of routine practice], we still have to observe consent and confidentiality’ [NGO representative_#15, 2009], suggesting the hegemony of these Western constructs in this setting. In short, the “3Cs” are worth invoking and defending, or so the words of the CTE might suggest.

A “but” usually qualified their statements, however. Stakeholders’ rhetorical commitments to this cluster of Western testing norms make their way onto paper, onto the official policy documents guiding counseling and testing. What is notable, however, is this group’s expressed ambivalence towards what strict adherence to the “3Cs” in practice means for the larger public health goal of getting the most people tested and—if found to be HIV positive—on antiretroviral treatment. As I met with one government respondent at her office headquarters one morning, she remarked quite unequivocally: ‘Those [the “3Cs”] are protocol, those are human rights issues… it’s a pillar [of testing programs], not a problem.’ However, as our conversation continued, she qualified her earlier remarks by describing HIV as an ‘evolving agenda,’ one that requires constant reformulation:

> ‘But there are emerging issues… it’s one thing to have guidelines there, but as [you are] revising [them], you have to address policy issues, and then you have to do refreshers [additional training], and then create new guidelines.’ She laments, ‘it’s a road to no end’ and talks about how you have ‘arrows’ pointing in many different directions. [Government representative_#12, 2009]

This representative's comments shed light on the difficulties in moving forward with policy changes in Malawi: policies must often keep up with global changes and demands, must involve the in-country collaboration of various international and national stakeholders, and then ensure that their front-line workers (HIV Counselors) are prepared to implement them. With a similar degree of conviction, another representative of the CTE notes:

> 'We cannot do without them [the "3Cs"]. This is why we are here. If you let them run [HIV Counseling and Testing be conducted] by medical doctors [as opposed to trained HIV Counselors], they will disappear.[27][We are here] to set the standards for counseling and testing…' [Government representative_#3, 2009]

Later in the conversation, however, the respondent seems less assured about the place for the "3Cs" in national efforts to increase the scale of testing: 'I try to balance both in my view [human rights and public health], but at the end of the day you have to be pragmatic – we want the [HIV] positives to access meds [antiretroviral medication] to avoid death' [Government representative_#3, 2009].

Notably, respondents from the CTE never expressed outright opposition to the "3Cs." But as illustrated above, their ostensible devotion to this cluster of Western testing practices is tempered by concerns about their compatibility with what they perceive to be the more important public health objective-- getting people tested so that if they are positive they can receive counseling on how to live with AIDS and, when eligible, treatment. Not surprisingly, however, they cannot directly object to the "3Cs,"

[27] By this, the respondent means that medical doctors are not trained in the ethics of HIV Counseling and Testing, the training course that is sponsored by the Malawi Ministry of Health.

since commitment to these principles is taken to be the defining characteristic of their important role in the AIDS industry.

In practice, however, commitment to the "3Cs" takes second place to adherence to protocol. And it is the focus on protocol, rather than the meaning of the "3Cs," that takes center stage in the training of HIV Counselors. In the HIV Counselor training, two hours of a three-week (full day, 8:00am-5:30pm) training course are devoted to a discussion of ethics and human rights,[28] 8 total pages of a 277-page training manual (Ministry of Health [Malawi] 2007b). As one respondent involved in the development of Malawi's HIV Counselor training manual recalls:

> 'I remember there being some discussions about confidentiality, some about choice…but I think there was a much stronger focus on protocol, following the protocol of the HTC session, from beginning to end, like introduction, [HIV] risk assessment, and all of those things…' [NGO representative_#2, 2009]

The official counseling and testing "protocol" contains three consecutive steps: pre-test counseling, testing, and post-test counseling (Ministry of Health [Malawi] 2004). When I inquired of members of the CTE about what they are looking for when they conduct their supervision of HIV Counselors at testing sites, the responses were largely formulaic: 'Are counselors following protocols' [NGO representatives_ #6 and #7, 2009], and to a lesser extent, 'quality assurance' [NGO representative_#11, 2009], which deals with issues such as the proper refrigeration of blood samples and an adequate supply of test kits. When asked specifically about where, if at all, adherence to the "3Cs" fell in the supervision of test sites, one HIV Counselor Trainer remarked quite

[28] See "HIV Testing Counselling: Training for Site Counsellors, *3-Week* Training" Schedule (revised June, 2007).

unequivocally: 'For us to know counselors are taking the issues [ethics] seriously, you have to ask the public [community]. [The] public is the best judge' [NGO representative_#13, 2009]. Inquiring of the public, however, is not part of routine supervisory practice (see Annexes, Malawi VCT Site Assessment Tool, Ministry of Health [Malawi] 2004).

In sum, while the "3Cs" are worth defending formally, they do not seem to be worth prioritizing practically. And, as the following sections will show, in this group's assessment, the "3Cs" pose problems for practice.

Consent

Consent for HIV Testing means that testing is both informed and voluntary (UNAIDS/WHO 2004). Of the "3Cs," the condition of consent is perhaps the most hotly debated, both in the global AIDS community and in policy debates in Malawi. Indeed, in Malawi, testing has long been promoted as something that every responsible person should do, even before it was widely accessible to the 85% of the population that lives in rural areas (Kaler and Watkins 2010: 7). But the recent international (and national) promotion of routine testing models for antenatal and diagnostic purposes has brought the issue of consent for testing (voluntary testing) into sharper focus. With routine testing (also called "opt-out"), those attending a health facility (pregnant women and those chronically ill) are informed by providers that they will be tested for HIV unless they explicitly refuse (WHO/UNAIDS 2007). In practice, opt-out testing maintains the language of consent, but shifts the initiative from the individual to the provider. Malawi's Parliament is currently debating legislation that would go even further away

from consent by mandating testing for certain categories of women: sex workers, domestic workers and those who are pregnant (Chipalasa 2009).[29]

Reactions to the current policy environment among the CTE is diverse. For some of those I interviewed, the dynamic policy climate did not alter their commitment to consent. As two different heads of NGOs that train HIV Counselors and provide testing services remarked:

> 'To me, it's just the wording…the process is the same, strategy is the same, [it is] just a matter of motivating the community [to test] – it [testing] is still voluntary.' [NGO representative_#5, 2009]

> 'We emphasize informed consent—this is behavior change—if [testing is] mandatory, behavior change is not going to take place.' [NGO representative_#6, 2009]

Other members of the CTE, however, expressed greater concerns about the challenges that the current policy environment poses to the effective implementation of consent. One concern was about the need for updated testing guidelines. At present, the last official HIV Counseling and Testing guidelines in Malawi were developed in 2004; in 2009, the year of my last round of fieldwork, the CTE were in the process of developing a third edition "post-ART," that is, testing guidelines more closely tailored to accessing treatment. The new guidelines, *inter alia*, are to include more detailed provisions for obtaining informed consent with routine testing and the testing of minors:

[29] Most policy decisions in Malawi require a vote by Parliament. Policies regarding HIV/AIDS, however, have been largely the purview of the Office of the President and Cabinet and the National AIDS Commission (Dionne 2010).

> ‘The [2004 VCT] guidelines say testing is voluntary, but now we are saying it should be offered as routine…at antenatal [clinics], women are told that one of the packages provided is testing…up to women to decide if she wants it… This needs to be clarified – a lot of people [providers] have made mistakes…nurses say, you can’t get [antenatal] services here [if you don’t get HIV tested]… they [providers] don’t understand [how to seek consent]. They are doing routine [testing] without guidelines.’ [NGO representative_#16, 2009]

> ‘We are planning now, once you go to facility, you should be offered [an HIV test], but providers are not yet sensitized [trained]…We want to have consultative meetings with the DHOs and then train trainers… it is the WHO guidelines we will follow.’ [Government representative_#17, 2009]

That the CTE respondents believe that better policy guidelines is a panacea, however, should not surprise: writing policy, and reports recommending better policy, is something they do as part of their job. And while the need for new, more clearly detailed guidelines for obtaining consent for testing may be part of the problem, they are likely no magic bullet either: health work—including HIV Testing-- is an inherently discretionary activity (Carter 2008; Pritchett and Woolcock 2004), as the proceeding chapter will explore in greater detail.

Another concern raised by members of the CTE with respect to the implementation of consent was about provider competency. As we met over lunch one afternoon, one CTE representative commented that the problem with opt-out testing is the need to improve ‘provider-client interactions:’ ‘[Provider-initiated testing] does not work properly because they [health workers] do not have the confidence or efficacy to do it’ [Government representative_#19, 2009]. Similarly, another respondent discussed at length the early resistance among health workers to implement the opt-out strategy in

Malawi, an effort for which he has long been a strong proponent. When I asked him where the resistance comes from, he explained: 'These things are very political…it would be big news in a small country [if testing was perceived as coercive]' and talks about how the hospital director would have to 'clear his name' [NGO representative_#4, 2009]. By this, the respondent means that opt-out might be administered incorrectly by health workers, that is, coercive in practice, and the hospital made subject to investigation.[30]

Two news articles from Malawi's leading newspaper, *The Nation*, attest to this very issue: "Pregnant Women Shun Hospital Fearing HIV Test" (Kumwenda 2006) and "Chief claims couples forced to test for HIV; DHO refutes claims of mandatory HIV testing" (Misunje 2008). In both articles, providers in two different rural districts were accused of forcing pregnant women to test for HIV during their antenatal visits. Health officials, interviewed by reporters, claimed that "they [women] are advised to do so [to have a test], not forced" (ibid: 2). Mary Shawa, Malawi's Health Secretary for Nutrition and HIV/AIDS, remarked that if coercion is happening, "it is an anomaly…government policy is that people should go for voluntary testing and should not be forced" (ibid: 2).

[30] Botswana was the first country in sub-Saharan Africa to begin routine, opt-out testing which it did on its own, that is, before it was promoted by the WHO in Geneva. Nonetheless, it did raise debates, particularly among human rights advocates, that in practice routine testing would threaten individual autonomy (Bayer and Edington 2009). Studies suggest that the majority of patients routinely tested in Botswana did not perceive they had the choice to say no to the test (Weiser et al. 2006).

HIV/AIDS
Maternity

NATION PUBLICATIONS
REFERENCE LIBRARY
DATE: 2 NOV. 2006
P.O. BOX 30408, CHICHIRI,
BLANTYRE 3

Pregnant women shun hospital fearing HIV test

by Olivia Kumwenda

Some pregnant women in Mponela, Dowa, are shunning the community's hospital—fearing

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that they will be forced to undergo an HIV test.

But hospital officials have disputed the claim.

Group Village Headman Mwamcheka from T/A Dzoole in the district on Tuesday alleged that when pregnant women go for ante-natal services or delivery at Mponela Rural Hospital, they are forced to go for an HIV test.

"This is not supposed to happen. The testing is supposed to be voluntary, one needs not be forced. As a result of this some women are

Pregnant women complain

avoiding the hospital and are delivering in the village where there are a lot of complications and some are getting in trouble with their husbands because they get tested without their knowledge," said the village head, sounding very concerned with the situation.

But the hospital's clinical officer Henderson Lomosi said in an interview yesterday that the women are not forced to go for testing but rather they are encouraged to do so.

"They are not being forced but are advised to do so. The policy is that they be counselled to go for testing and they can have their blood taken for testing but they are not told the results if they don't want to. The results are given after consent and this is happening in other hospitals as well," said Lomosi.

Ministry of Health Principal Secretary (PS) Wesley Sangala said he is aware of the issue but could not discuss it because he is retired.

PS in the Office of the President and Cabinet on Nutrition and HIV and Aids Mary Shawa said she is not aware of the issue. But she said nobody is forced to know their status.

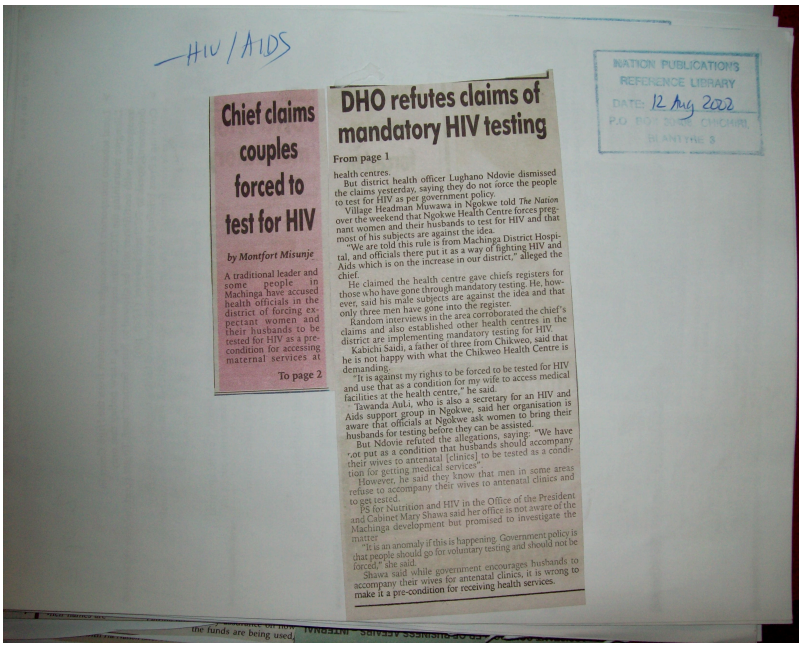
"What I know is that people are counselled and [they] decide on their own to go for testing. If you are pregnant, there is an advantage of knowing your status because you get the proper medication for yourself and the child," said Shawa.

She said the women in Mponela are either not properly counselled or someone is giving them wrong information to scare them.

Commenting on the issue, bioethics professor Mfutso Bengo said:

"It would depend on the policy which is there. Mostly this is done in the best interest of both the mother and the child but to say if you don't do it, you won't give treatment them that's something different."

Figure: 2.1. Newspaper article from *The Nation*



HIV/AIDS

NATION PUBLICATIONS
REFERENCE LIBRARY
DATE: 12 Aug 2002
P.O. BOX 30408, CHICHIRI,
BLANTYRE 3

Chief claims couples forced to test for HIV

by Montfort Misunje

A traditional leader and some people in Machinga have accused health officials in the district of forcing expectant women and their husbands to be tested for HIV as a precondition for accessing maternal services at

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DHO refutes claims of mandatory HIV testing

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health centres.

But district health officer Lughano Ndovie dismissed the claims yesterday, saying they do not force the people to test for HIV as per government policy.

Village Headman Muwawa in Ngokwe told *The Nation* over the weekend that Ngokwe Health Centre forces pregnant women and their husbands to test for HIV and that most of his subjects are against the idea.

"We are told this rule is from Machinga District Hospital, and officials there put it as a way of fighting HIV and Aids which is on the increase in our district," alleged the chief.

He claimed the health centre gave chiefs registers for those who have gone through mandatory testing. He, however, said his male subjects are against the idea and that only three men have gone into the register.

Random interviews in the area corroborated the chief's claims and also established other health centres in the district are implementing mandatory testing for HIV.

Kabichi Saidi, a father of three from Chikweo, said that he is not happy with what the Chikweo Health Centre is demanding.

"It is against my rights to be forced to be tested for HIV and use that as a condition for my wife to access medical facilities at the health centre," he said.

Tawanda Auli, who is also a secretary for an HIV and Aids support group in Ngokwe, said her organisation is aware that officials at Ngokwe ask women to bring their husbands for testing before they can be assisted.

But Ndovie refuted the allegations, saying: "We have ·,ot put as a condition that husbands should accompany their wives to antenatal [clinics] to be tested as a condition for getting medical services.

However, he said they know that men in some areas refuse to accompany their wives to antenatal clinics and to get tested.

PS for Nutrition and HIV in the Office of the President and Cabinet Mary Shawa said her office is not aware of the Machinga development but promised to investigate the matter.

"It is an anomaly if this is happening. Government policy is that people should go for voluntary testing and should not be forced," she said.

Shawa said while government encourages husbands to accompany their wives for antenatal clinics, it is wrong to make it a pre-condition for receiving health services.

the funds are being used.

Figure 2.2. Newspaper article from *The Nation*

In sum, the CTE strongly promote HIV Testing on public health grounds and indeed, as part of their jobs. The current debates surrounding routine testing has

essentially put the issue of consent up for grabs, thereby rendering all the more important their current positions in the AIDS industry to protect it.

Confidentiality

Confidential HIV Testing, a second cornerstone of HIV Testing, is envisaged to protect those who test HIV positive from stigma and discrimination (UNAIDS/WHO 2004). The HIV/AIDS Counseling and Testing Guidelines for Malawi explain why confidentiality is important:

> CT [Counseling and Testing] services should adhere to the ethical principles of confidentiality governing clinical care that protect and promote the privacy of clients. Personal information obtained in the CT setting regarding a client's use of CT services, medical condition or HIV status should not be divulged in ways inconsistent with client's original consent. Although CT services are anonymous in principle, when CT services are an entry point for other medical services, such as PMTCT, TB treatment and prevention, prevention and treatment of other opportunistic infections or sexually transmitted diseases clients' names and results might be recorded on the specific referral form. This should only be done with the knowledge of the client. (Ministry of Health [Malawi] 2004: 11-12)

Like the implementation of consent, the implementation of confidentiality also is imperfect in this group's assessment. While strict adherence to the principle of consent is problematic because it is perceived as impeding progress in improving public health, confidentiality is problematic because it is perceived as a barrier to identifying those who are positive and thus need to be monitored for eligibility for ART.

In several African languages, including Chichewa, Yao and Tumbuka (Malawi's three most prominent languages), confidentiality overlaps with other, similar notions, including secrecy, privacy, discretion and anonymity (Whyte, Whyte, and Kyaddondo

2010).[31] This was an issue raised by some members of the CTE, who see a clear understanding of (medical) confidentiality as an important distinction from its related family of ideas:

> 'There is a difference between confidentiality and privacy….With confidentiality, someone can know your result if that can help you – for professional purposes to handle your condition, so [it] is always maintained in HTC service provision.' She describes privacy as something that is important if HTC is conducted outside of a counseling room—'in a community, no one can hear your results.' [Government representative_#17, 2009]

Another respondent was more critical, however. As we chatted over afternoon tea in her living room, she pilloried the (global) misconstruction of confidentiality, which she perceives as an impediment to curbing the pandemic:

> 'The big thing about confidentiality – not only in Malawi, but all over sub-Saharan Africa or even globally—is that people seem confused over the understanding of confidentiality. In the States [U.S.], it's one thing,' and talks about how people understand confidentiality as allowing your doctor to know about your health condition and to refer you to another doctor. 'Here [in Malawi], people think if you write their HIV status in their health passbooks[32] you are violating confidentiality…' [Donor representative_#1, 2009]

An interview with a government representative echoes this respondent's concern that confidentiality is misinterpreted in Malawi. The respondent first presents confidentiality—all of the testing norms in fact—as seemingly unproblematic, as 'human rights issues.' Yet she simultaneously proclaims that the fidelity of confidentiality, at least her understanding of it, is undermined by national efforts to get the infected on treatment:

[31] Indeed, there was early concern in the development of responses to the global AIDS pandemic that confidentiality was confused with anonymity (DeCock, Mbori-Ngacha, and Marum 2002).
[32] The health passbook is a small, yellow, individualized medical record that people are asked to purchase and carry with them if they are seeking health services.

> ‘With confidentiality, we have to break [it] with [ART] referrals…somewhere it has to break… as we implement [it], we have to monitor and balance [it]… in [the early] days, we had codes, but now you need to break coding for referrals [for ARV services, e.g.]… I need your name so we should follow you, which is a process…it’s one thing to have theories [like confidentiality], but when you implement [them], they change.’ [Government representative_#12, 2009]

This informant’s remarks refer to the fact that the government of Malawi has not yet fully standardized across testing sites its approach to recording test results in a patient’s health passbook. Rather, recording methods vary from health center to health center, making it difficult for health personnel to identify those who might need treatment. The 2006 country-wide situation analysis, an annual inventory of HIV/AIDS services in Malawi conducted by various arms of the CTE, makes explicit note of this:

> Due to concerns over confidentiality, many [testing] sites had developed custom methods for encrypted recording of HIV test results in patient health passports…The SA [Situation Analysis] 2006 facility assessment form did not specifically ask for practices of recording negative test results, but most sites also recorded these and the field teams noted down some codes used for negative results. This brought to light that several of the codes used to signify positive test results were used to signify negative test results by other sites. This observation is of particular concern because some [pregnant] women are likely to attend different facilities for antenatal care and delivery and there is a conceivable risk that such codes in health passports would be misinterpreted at other facilities, leading to inappropriate management. (HIV Unit Department of Clinical Services MOH, National TB Control Program, Lighthouse Trust Lilongwe, and Centers for Disease Control and Prevention (CDC) Malawi 2007: 37-38)

To illustrate, the table below is an abbreviated version of a table presented in the 2006 situation analysis on the various methods utilized across testing sites for recording maternal HIV status in a patient’s health passport:

Table 2.1. Differential Recording Methods for HIV Positive Test Results

Recording Method Used in Patient's Health Passport for "HIV Positive"	Number of Antenatal HIV Testing Sites Utilizing Method
1. ' * PMTCT * '	1
2. ' * PMTCT * ' or ' * PMTCT R * '	2
3. ' ID-R'	1
4. ' NVP'	1
5. ' PMTCT * '	1
6. ' PMTCT +ve'	1
7. ' Pre and Post test counselling done'	2
8. ' Pre and Post test done' and '7' or '8' or '9'	1
9. ' To attend PMTCT and HIV clinic'	1
10. '+'	2
11. '1' or '2' or '3' or '4' or '5'	19
12. '1' or '2' or '3' or '4' or '5' or '6' or '7' or '8' or '9'	3
13. '1' or '2' or '3' or '4' or '5' or '6' or '7' or '8' or '9' or '10'	4
14. '6' or '7' or '8' or '9'	2
15. '6' or '7' or '8' or '9' or '10'	3

Source: "Report of a Country-Wide Survey of HIV/AIDS Services in Malawi for the Year 2006"

The different types of reporting across testing sites is something that HIV Counselor Trainers must explain to their trainees who, once working as HIV Counselors, are responsible for handling by putting a patient's test result in their health passport. In my observation of an HIV Counselor training course, Charity, one of the trainers, explains to the trainees: 'Different sites use different symbols to indicate who is reactive [HIV positive]…At one site, 1-5 might indicate reactive [HIV positive], 6-10 non-reactive [HIV negative], but that can be reversed at another site.' She further explains to

the trainees that there are 'calls to standardize symbols of [HIV] serostatus, but the stakeholders [CTE] have not yet agreed [on what that system will be].'

The absence of a standardized system for recording test results has, as the CTE suspect, created confusion in health facilities. Sekou, an HIV Counselor, described to me a case he handled whereby an elderly woman came to him to be tested, but her health passbook already indicated that she was HIV positive. When he tested her, her test result came back HIV negative. The confusion was caused by differential recording systems: the facility at which she was first tested had a reverse coding system for test results than the facility where she went for her second test. Sekou explained to me that he tried to raise this concern with more senior medical personnel, including the District Health Officer,[33] by suggesting they use "R" (reactive, HIV positive) or "NR" (non-reactive, HIV negative) in a client's health passport rather than numbers. But, he explained to me, 'they [senior medical staff and the DHO] were saying we have to protect confidentiality' [Counselor Sekou, 2009].

Like the issue of consent, confidentiality at this level, with this group, is also problematic on public health grounds and must be addressed. But, unlike consent, it does not seem to be an issue to which their current efforts or concerns are as strongly focused.

[33] The District Health Officer is responsible for the overall coordination of the District HIV Testing and Counseling strategy as well as -- in consultation with the HIV/AIDS Unit at the Ministry of Health-- the assessment, development, implementation and supervision of all HIV Testing and Counseling services. (Ministry of Health [Malawi], 2006b: 11)

Counseling

Counseling for HIV is a third cornerstone of global and national testing policy (Ministry of Health [Malawi] 2004; UNAIDS/WHO 2004). In the interviews with CTE members, there were fewer qualifications to the importance of counseling than either consent or confidentiality. This is not to suggest, however, that counseling works perfectly in the CTE's assessment, nor that there is complete consensus among them about what counseling should consist of.

According to global and national policy, counseling is meant to take place twice during the HIV Testing session: before the administration of the HIV test ("pre-test" counseling) and after the test results are given ("post-test" counseling), a detailed illustration of which is presented in the proceeding chapter (Chapter 3). During pre-test counseling, HIV Counselors provide basic information about HIV, assess a client's individual risk for infection, discuss the implications of a positive or negative test result, and obtain a client's consent for testing. During post-test counseling, counselors reinforce the importance of behavior change to avoid putting oneself at risk for HIV or giving it to others (such as about abstinence, faithfulness and condom use) and discuss with clients appropriate referrals for services and/or treatment (Ministry of Health [Malawi] 2004; Ministry of Health [Malawi] 2007b).

In the international AIDS community, counseling has been controversial with the promotion of routine testing policies. The debates rest largely on how much counseling is needed such that testing is considered truly informed (Bayer and Edington 2009), discussions which have also taken place among Malawi's CTE. One CTE member

explained that when the Government of Malawi changed the counseling and testing acronym from "VCT" to "HTC," a change aimed to reflect the mainstreaming of HIV Testing for antenatal and diagnostic purposes, there was a 'huge debate' about whether it should be called "HTC" (HIV Testing and Counseling) or "HCT" (HIV Counseling and Testing). The debate, the respondent explained, hinged on whether the placement of the "C" implied a de-emphasis on the pre-counseling component of the testing protocol:

> 'A lot of people believed pre-test counseling was not important.' She explains that it was an 'on-going discussion': 'There were a few people… I don't know where the Ministry of Health [stood]… some of the donors thought it was not important… you don't know if it's individual personalities [or the institution]...She continues, 'Pre-test counseling should be institutionalized, not dropped.' [Government representative_#19, 2009]

The reason that CTE members debate the import of pre-test counseling is that it is time-consuming: in busy test sites, where health workers are few and client demand is high, devoting extensive amounts of time to counseling may impede testing people quickly and efficiently. But it is also seen by this group as a critical opportunity to provide clients with important information about HIV. Pre-test *group* counseling is thus endorsed officially as an alternative to individual counseling. With group counseling, HIV Counselors are to focus on imparting more general information about HIV/AIDS and obtain a client's consent for the test.

In addition to concerns about the form and content of pre-test counseling, another (related) concern among CTE respondents about the implementation of counseling was the dearth of available resources-- both human and monetary-- to implement it. One

representative of an NGO providing testing services explains the gap among expectations from the WHO and the NAC and what is happening on the ground:

> 'The WHO recommends a ration of 1 counselor to 8 clients/day…the NAC said 1 counselor to 15 clients/day. He explains that in [testing] outreach, you find 1 counselor/20 clients. 'So you ask, are they [counselors] really doing counseling?' He adds that clients are saying 'forget counseling' [clients don't want it], laughs and continues, 'so maybe it is "HT" [HIV Testing] not counseling [HTC].' [NGO representative_#7, 2009]

I ask about the prospect of dropping counseling from the testing protocol, since in his assessment, it is already compromised in practice and unpopular among its beneficiaries.[34] He defends the import of counseling, however, both from the perspective of the organization with which he is employed and as a practice in and of itself:

> '[We are] not comfortable as an organization [to drop counseling]…I think counseling is important psychologically…So we are asking for more counselors, but they [NAC] are saying we don't have the funds…counseling is the first to go with high demand—we have group counseling, but you still need individual [counseling].' [NGO representative_#7, 2009]

Other CTE respondents see the problem with the implementation of counseling as less about demand than about the competency of counselors to handle the task. As one informant, an HIV Counselor Trainer, explains, 'Counseling is supposed to be individualized, but you find [in observing HIV Counselors], that it is not' [NGO representative_#13, 2009]. She continues:

[34] Rural Malawians are well aware of how HIV is transmitted and how to avoid getting it (Watkins 2004).

> ‘Counseling and advice giving are not the same thing… you are supposed to guide [the person]… [the client] has to make a contract with him/herself, not the counselor told me [to do] x and y…for example, you may identify a problem in me, you say, you should stop 1,2,3… do you think I’m going to stop? But if you say, Emily, your problem is this, what do you think you should do, maybe I’ll say I should use a condom, be faithful, and then when I come home, my conscious is reminding me things I’m supposed to do…’ [NGO representative_#13, 2009]

As explained in Chapter 1, the expansion of testing services required expanding the number of trained health personnel to implement the testing. One category of health workers that were trained as counselors as part of the scale-up were Health Surveillance Assistants (HSAs), a category of nonmedical personnel who deal with general community health needs such as sanitation and the distribution of bed nets. This approach to expanding lay counselors appears to have been largely unsuccessful in this group’s assessment. Counseling and testing is additional work responsibility for HSAs, one which comes without additional pay. The HSAs are often seen as mercenaries, motivated only by “refresher courses” (additional training courses) for which they are compensated in the form of per diems-- daily funds which typically cover meals, other incidentals and travel allowances. HSAs are often the ones blamed when program delivery suffers. As one respondent explains of his supervisory role of HIV Counselors: ‘There are competency problems with counselors. So we come in [to supervise them]’ [NGO representative_#9, 2009].

Given these concerns, what then do members of the CTE see as the solutions to counseling? The short answer is simple: money. As one respondent notes, ‘we have to be prepared to cough a lot [give up a lot of money to add more counselors] [NGO

respondent_#7, 2009]; and another, who said she'd like to see 'more money for [counselor] trainings' [NGO respondent_#13, 2009].

DISCUSSION

This chapter examined the ways in which HIV Testing's "3Cs" (consent, confidentiality and counseling) are professed by members of the Counseling and Testing Establishment, what this group sees as their problems for implementation, and their solutions.

There is indeed consensus about the place for the "3Cs" in matters of testing among the CTE, and no respondent said testing should be conducted in their absence, illustrating the hegemony of these Western constructs. Their "foreign provenance" appears to make them attractive and worth defending, at least rhetorically so (Luke and Watkins 2002). While CTE members recognize some of the difficulties that the "3Cs" pose for implementation, by in large, they did not see them as inherently antithetical to getting people tested—their primary goal. Rather, they were framed as something that can be remedied by the strategies that their professions are designed to handle-- new guidelines for consent, better reporting systems for confidentiality, and more training and supervision for counseling—thereby asserting and reaffirming the importance of their roles and positions in the AIDS industry. It should not surprise that members of the CTE are protecting the institutions that feed them: these individuals have a reputation to maintain, a standpoint based on their own training and background, a job to protect, and of course, families (often, extended families) for whom to provide. But the solutions they propose are likely no antidote either, as the next chapter (Chapter 3) will illustrate.

This is certainly not to suggest that the CTE is short-sighted in their perspectives about the problems and solutions as it regards HIV Testing, that their intentions are mercenary, nor that they are docile recipients of Western imports. As shown, some respondents expressed concern, even frustration, about the challenges posed to the effective implementation of testing by the "3Cs." As illustrated in the words of one government official: 'No matter how much you train [counselors], ethics ["3Cs"] will be challenged. I am aware of this' [Government representative_#3, 2009]. In some ways, Malawi's CTE may have inherited a mess, that of largely unsettled issues in the global AIDS community that involve balancing public health objectives with international conceptions of human rights, discussed in Chapter 1. And to make matters more complicated, the CTE are also accountable to foreign donors that are most concerned with seeing the numbers of people tested (and if HIV positive, on treatment) increase, outcomes that are much easier to measure, monitor and evaluate than adherence to human rights principles (for example, see The Global Fund to Fight AIDS, Tuberculosis and Malaria 2009). Malawi's HIV Counseling and Testing project reports are replete with extensive sections that detail quantifiable successes (also see Smith 2003): numbers of individuals tested for HIV, numbers of new testing sites established, numbers of individuals placed on ART, and the numbers of trained (and working) health personnel (Ministry of Health [Malawi] 2006b; Ministry of Health [Malawi] 2007a; National AIDS Commission [Malawi] 2007). Thus these priorities may trump those of adherence to ethics/human rights, until something goes wrong that their professions are designed to "fix."

In the next chapter, I consider what happens on the ground; that is, how the foot-soldiers of HIV Counseling and Testing—the HIV Counselors-- understand and adapt to local concerns at the village level, the policy and programming efforts of the CTE.

Chapter 3
Counselors: A View from (in) Between

Early morning, Kondwani and I begin our drive to the M'Dindi District Hospital. It is raining and the power is out, thus complicating our commute over muddy, unpaved roads. We arrive at the Hospital, later than we had hoped, but nonetheless at a respectable morning hour: 8:30.

We make our way through the long, congested open hospital corridors, where nurses are weighing patients on scales outside the wards and female guardians are sitting on the grass engaging in light chatter. The HIV Counseling and Testing section is labeled "VCT" prominently in black paint. The specific services offered are listed in red paint below it: Antiretroviral Therapy, Voluntary Counseling and Testing Services, Leprosy Skin Clinic, Sexual Transmitted Infections Clinic. Kondwani takes a seat in the ARV guardian waiting area. I open two wooden doors and enter the HIV Counseling and Testing waiting area. The walls are adorned with photos and signage, one which reads "Chidziwitso: Tikhale Pampando Didikira Thandizo," meaning "NOTICE: Take a seat while you are waiting to be assisted." The square-shaped waiting room is packed with men and women sitting shoulder to shoulder, waiting patiently to be seen. Apart from a cacophony of coughing, and the occasional fussy baby, the room is remarkably quiet.

I pass through to the HIV Counseling and Testing room, on which a sign is displayed on the door, "Counseling in Progress: Do Not Enter." The HIV Counselor gives me permission to enter the room. The room is dim, its dimensions short and narrow. There is one small window, with orange fabric curtains that are nearly closed. In

the corner of the room is a wooden desk with two open drawers, on top of which a large, pink Ministry of Health HIV Testing register is displayed prominently. A bookshelf stands adjacent to the desk and contains nothing but a stack of used pink registers and loose sheets of paper. Lining the walls are six green plastic chairs, a small refrigerator, a small wooden table containing the testing materials, and a few purple waste bins marked clearly for their materials. On the walls there are posters with information about HIV Testing, including the steps involved in taking the test; how to interpret the test kits (one red line means HIV negative; two red lines means HIV positive); information about STI symptoms; a public health reminder about the importance of washing hands; and a large poster board listing the numbers of individuals tested each month (January – December) divided into three columns: total, male and female. Twice as many women as men are tested each month.

The counselor opens the door to the counseling room and six individuals file in, each taking a seat on one of the green plastic chairs. The counselor welcomes them with a gentle smile, clasping his hands together and nodding his head downward. He reminds the group that they are there for an HIV test, which is a blood test, and asks if they all agree that they are there for a test. They nod yes as if they are in school, responding to a teacher. He hands them each a small, cubed piece of paper containing a number, which they retrieve by placing their hands out in a cupped-like position. The counselor says 'anonymous' in English, explaining that their names will not be used. He then writes the number they each have in their hands on an individual test strip, which he places in a row on the wooden table. He asks the group what they know about HIV, like a test, and

then explains to them how HIV is transmitted and how long it takes for a person exposed to HIV to start showing signs that his/her immunity is low. He then explains that HIV is a human virus, that it takes up to three months for HIV to be found in the body, and that it can take up to 10 years to develop AIDS-related disease.

The counselor shows the group the test strip, which they all stare at with great interest, leaning forward gracefully in their chairs in a seemingly rehearsed unison. The counselor puts on a pair of white plastic gloves and hands each individual a piece of cotton. He dips a piece of cotton in a purple solution, which had been poured into the lid of the bottle in which it was contained. He starts with the first client, cleans her index finger, and with a lancet taken out of its wrapper, briskly pricks her finger. Her body pulses upward. She giggles, surprised by her corporeal response. He then takes out a plastic capillary tube, places it on the pricked finger, and draws the blood, squeezing her finger when necessary to keep the blood flowing and lifting his own index finger on and off the top of the tube until it is full. He then drops the blood sample on the bottom of the test strip and adds a drop of solution. The woman holds the cotton over her pricked finger. He repeats this process for every client, including a 4-year-old boy, who struggles to keep his tiny fingers still.

The six clients exit the room. After about five minutes they begin to return, one at a time, to meet with the counselor. The first to re-enter the room is an older woman, about 50 years old, dark skinned and overweight, and dressed in a chitenje and a torn white blouse. She has only a few teeth remaining in her wide mouth. She is holding a torn piece of fabric in her left hand, which she places occasionally over her face as she

clears her throat. She takes a seat on the chair adjacent to the desk, placing her hand across her chest and inhaling deeply. The counselor greets her – 'amayi, muli bwanji?'—and asks her for the number in her hand. She hands it to him. He then takes the piece of paper and goes to the table on which the test kits are lined and grabs her corresponding test strip. He returns to his desk. He asks her some basic information—her date of birth, marital status-- which he records in the large pink register in front of him. He doesn't place the test strip in front of her, but rather moves it in front of the register. He asks her if she is ready to receive her results. She says yes. He tells her that her test results indicate that she is HIV negative. She is relieved. He records her results in the register by circling NR ('non-reactive'), instead of R ('reactive'). The woman explains that her daughter—waiting outside for her-- had brought her to the hospital to be tested because of the problems she was having with her asthma. She thanks the counselor graciously and leaves the testing room.

The second and third clients enter. It is a young mother, about 25 years old, light skinned and very thin, and her 4-year-old son, resting calmly on her back. Her hair is wrapped in a green and blue fabric and knotted on the right side of her head. The young boy is wrapped in a chitenje printed with pictures of the current president, which is tied like a cape over his shoulders. He has big brown eyes like his mother and they are extraordinarily watery. He is coughing and has a runny nose, which his mother wipes for him. When his coughing subsides, she grabs from her bag a used water bottle with the label removed to let him sip from it. She takes a seat, hands her number to the counselor, who grabs the two test kits from the testing table. Both kits contain two red lines,

indicating that she and her young son are both HIV positive. He shares their results with them and asks for their health passports. When the counselor opens their health passports, he's surprised to see that it already notes that both the woman and her son are HIV positive. He runs his hand over his head, clearly puzzled. The mother explains to the counselor that she has come to get her 'immunity tested.' The counselor leaves the testing room to investigate her case. After consulting with the ARV clerk, he learns that she is not only HIV positive, but currently taking ARVs. He returns to the counseling room and explains to her that the HIV test is about finding the virus in your body, not testing immunity. She leaves the room with her son, seemingly content. The counselor is frustrated. He blames her mistake on the erroneous messages that people in the community share with one another about what HIV testing is for.

The fourth client is a young man, about 19 years old, dressed smartly in long stone-washed jeans and a neatly pressed button-down beige and white shirt. His dark skin is smooth, his body toned, and his smile white and bright. He is a youth worker in the community and comes every three months to the M'Dindi District Hospital to be tested. He greets the counselor familiarly, shakes his hand, quickly takes a seat, and hands his number to the counselor without instruction, suggesting that he knows the drill. The counselor grabs his test strip, which registers HIV negative, and records the information in the pink register expeditiously. Before he leaves the room, the counselor opens a white box on his desk and removes about 10 condoms from it, which the young man instantly shoves in his right jean pocket. He leaves.

The fifth client is a woman, about 30 years old. She is light skinned, medium build, and dressed in a red chitenje and pink silk blouse with big white buttons, the third one of which is dangling from a single thread. She takes a seat and promptly rotates her baby daughter from her back, where she is wrapped in a matching fabric, to her chest. She removes her right breast from her blouse and starts feeding her. The counselor takes the woman's number and grabs her test kit. He tells her she is HIV negative. She is seemingly not content with her results and explains that it is her third time being tested. Looking down at the floor, and occasionally at her baby attached to her breast, she says that she is worried that her husband- who she claims is 'movious'[35]- has infected her. She says he is out late at night and she suspects him to be HIV positive. At different moments, she stands up from her seat to rock her child, who, in between her sucking, gets restless. The counselor, listening attentively, suggests to her that she find ways to make herself more 'marketable' to him so that he won't be tempted to find other women. He says that couples sometimes get too 'takulirana.'[36]

The last client of this session is a man, about 40 years old. He is tall, thin and coughing profusely. His clothes—a pair of brown pants and a blue v-neck sweater-- are ragged and torn. He is wearing a ski cap, awkwardly placed on his head. His left eye is glossed over in white, suggesting he is either partially blind or has a bad cataract. He takes a seat, leans his back against the wall, and places his hands on the top of his legs. He hands his number to the counselor, who then grabs his test strip, which contains two

[35] 'Movious' is a term used locally to describe individuals who have multiple sexual partners. It is an "Anglicization of a Chichewa expression, *woyendayenda*, derived from the earlier association of multiple partners with migrant labor" (Watkins and Swidler 2009:6).
[36] 'Takulirana' in Chichewa means "accustomed to one another."

red lines. He shows the test strip to the man and explains to him that his first test indicates that he has the HIV virus, but that they would need to run a confirmatory test. The counselor then stands up and grabs another testing device. He puts on a new set of plastic gloves, grabs another lancet and capillary tube, and takes blood from the man's middle finger. After a few minutes wait, he places the two test kits side by side on his desk so the man can see them, indicating to the client that both tests show two red lines and that he is indeed HIV positive. The man is stoic, responding to his diagnosis with a 'oh-ho,' signifying 'I see.' He pulls a dusty white envelope out of his right pant pocket, which contains a handwritten letter that he presents to the counselor. The letter was from a doctor in South Africa, where the client had been working for several months in construction, saying that he needed to go back to Malawi to get tested for HIV. The counselor asks for his health passbook, where he notes he is HIV positive, and refers him to the ARV consultation room across the hall. It is approaching 1pm, however. The client lost his opportunity today to be seen by the ARV clerk, who just arrived to meet the counselor and break for lunch.

The delivery of HIV Testing programs throughout sub-Saharan Africa relies on the work performed by trained HIV Counselors. HIV Counselors occupy a critical position: they are intermediaries between the rule-making of the CTE and the norms of the communities in which they live and work. While their task of translation is indeed literal, it is more so applied, and it is the application that is often riddled with difficulty for them.

An established literature on the role of intermediaries suggests that they modify, transform or even subvert institutional rules in the course of doing their jobs (Merry 2006; Portes 2006). The work of intermediaries has been the subject of several other empirical studies, including community-based distributors in rural Kenya (Kaler and Watkins 2001) and colonial Zimbabwe (Kaler 2003b); nurses in Kenya (Booth 2004); and traditional birth attendants and healers in Nepal (Pigg 1997). Less attention has been paid to the work of HIV Counselors, however, who as intermediaries, directly link the policies and programs developed by the CTE to their intended beneficiaries (for exceptions, see Paoli, Manongi, and Klepp 2002).

In rural Malawi, how HIV Counselors interact with clients varies: sometimes it is quick and formal, as much of the opening field note illustrates; but other times they interact with clients who are also as family members, neighbors, friends and/or fellow church members. Consequently, Western-oriented testing guidelines are altered in practice at the local level as counselors find themselves imbricated in situations necessitating their innovation: they must reconcile the contradictions and conundrums they face in their professional commitments to uphold the ethical requirements of their jobs (the "3Cs"), with moral (as well as neighborly and familial) concerns for those whom they were trained to help (see Whyte, Whyte, and Kyaddondo 2010 for health workers in rural Uganda).

In the sections that follow, I consider the adaptation-in-practice of testing's core tenets—consent, confidentiality and counseling—by the foot soldiers of HIV Testing programs, HIV Counselors. I draw upon interviews with HIV Counselors, observational

field journals and participant observation. The interview questions focused on the "3Cs" (consent, confidentiality and counseling), specifically how HIV Counselors understand these testing guidelines and how they operationalize them in practice. Asking counselors how they understand testing guidelines, however, proved largely unfruitful: the majority simply repeated material from their training manuals. When asked to talk about their actual experiences as it regards counseling and testing, however, their ambivalence about them became clear. Significantly, counselors also talked about themselves as role models in their communities, as having changed their own behavior on account of their training, and as well-trained missionaries of public health.

To forecast that which follows: while this group formally expresses an almost slavish devotion to the Western constructs of consent, confidentiality and counseling ("3Cs"), they have ambivalent views about them. Many, therefore, seek solutions to maintain the fidelity of testing principles, or at least fidelity to what they believe is the program's main aims, while reducing the harm they perceive will arise as a consequence of strict adherence to them.

HIV COUNSELORS

HIV Counselors must be fluent in English, be at least 18 years old, and possess a Malawi School Certificate of Education (Form 4 graduate), the equivalent of a secondary school education. In some cases, individuals with a Junior Certificate of Education (Form 2 graduate) are considered for training (Ministry of Health [Malawi] 2007b). The counselors are individually selected, usually by a sponsoring donor organization, or by the health facilities in which they were employed in a different

capacity (such as Nurses/Midwives, Health Surveillance Assistants), to participate in a training course sponsored by the Ministry of Health.

In training, counselors are reminded by their trainers of their mandate as 'torch bearers.' In a HIV Counselor training course I observed, one message was almost a daily one: 'If we have enlightened our clients,' the trainer explains, 'we have done our jobs.' Perhaps not surprisingly, in interviews with HIV Counselors, virtually all talked about how they themselves have changed their own behavior on account of their training; on the importance of clients learning how to differentiate HIV from AIDS and of the "window period" (the 3-month period it takes the body to develop antibodies to HIV); of teaching about the importance of abstinence, fidelity and condom use; and in the virtue of "knowing your status." In short, HIV Counselors learn to see themselves as certified missionaries of the HIV prevention gospel. Perhaps significantly, many blamed villagers for spreading "misconceptions" about HIV– what it is, how to avoid getting it and how ARVs work – in effect asserting the importance of their mandate to "spread the word," as it were, about a deadly disease. The importance of acquiring imported jargon has been observed by others (for examples, see Englund 2006; Pigg 1997; Richey 2008; Rutenberg and Watkins 1997), who note that it sustains modern, educated identities as distinct from ordinary folk. Many counselors distinguished themselves from villagers because they possess a Western biomedical repertoire that those in their communities do not have.

Being a certified HIV Counselor, however, does not come necessarily with additional material perks. In Malawi's health facilities, understaffing is common and

salaries low. Once certified, those already employed as health personnel in other capacities have the task of counseling and testing added to their existing job responsibilities, though without extra compensation. Paid HIV Counselors earn about $58 USD a month, or can work on a volunteer basis until a paid position opens. Paid counselors earn only $3 USD more per month than a hospital attendant, a position that requires no formal education or training (Fleming et al. 2007). Those counselors working for NGOs earn slightly more and have the added benefit of closer ties to Western donors and development organizations.

In the sub-sections that follow, I focus on when, how and why HIV Counselors adapt the "3Cs" to local concerns at the village level, which significantly is a social setting they jointly inhabit with the intended beneficiaries of testing programs.

Consent

> When I asked him what voluntary means, Willie replies 'giving yourself, not being forced.' And when asked how clients understand voluntary testing, he responds that clients don't understand what voluntary means: 'Voluntary is an English word,' he explains. 'They just know that VCT is where people go for testing.' [Counselor Willie, 2007]

Officially, consent means that HIV Testing is both informed and voluntary: "Counsellors must obtain their clients' consent to engage in the counseling and/or HIV Testing process" (Ministry of Health [Malawi] 2007b: 258). Most counselors recognize that many clients who come to be tested do so under pressure, or are at times forced, the reasons for which may vary. In many cases, clients are already quite sick; an HIV test, then, may help confirm the source of their illness. Gertrude, a counselor in her mid-40s,

explains how she handled a recent case of a client suffering from tuberculosis, which rural Malawians recognize as one of the telltale signs of AIDS:

> Gertrude explains that the client said, 'I don't want [this blood test]…I can easily die.'[37] She continues, 'I counseled and counseled and counseled her and made an appointment for her to return…they must come voluntarily because it [testing] is voluntary.' She said that the client returned on the 22 of June. I express my surprise that she remembered the exact date. Gertrude laughs and says, 'It's my client!' She explains that they are not taught to book appointments in training: 'It's my own [idea]…They told us not to force [people to get tested] in training.' Gertrude reasons, 'It's my job to make a client have a life like I am [like I have].'[38] [Counselor Gertrude, 2007]

Indeed counselors often gauge the efficacy of their work as hinging on clients agreeing to be tested. Reflecting on her experience with testing pregnant women during their antenatal visits, Alice, a counselor in her mid-20s boasts, 'No one has said no [I don't want an HIV test] to me' [Counselor Alice, 2007]. Elizabeth, a counselor in her mid-40s, elaborates the extreme measures for getting pregnant women tested exercised in the health facility where she works:

> Antenatal testing, she says, is 'mandatory.' When asked if women sometimes don't want to be tested, she says 'yes' and that many women 'look really sad because they don't know how the results will be.' She adds proudly that when they test negative, they 'shake my hands.' Asked if they can say 'no' to the test, she says the nurses say to them, 'if you are not tested, you cannot get antenatal services.' [Counselor Elizabeth, 2007]

Willie, a counselor in his mid-30s, explains that at his health facility, they encourage women to bring their husbands with them to their antenatal visits, but women often say they are 'busy or away' [Counselor Willie, 2007], suggesting that women are either

[37] It is widely believed that receiving a formal diagnosis as HIV positive is so emotionally devastating that the individual will die more quickly (Kaler and Watkins 2010).
[38] By this, the counselor means that it is her job to keep the client alive.

making excuses for their husbands because they themselves don't want to be tested, or that they don't want their husbands to know their HIV status.

Throughout sub-Saharan Africa, the HIV/AIDS epidemic is generalized, meaning it spreads primarily through heterosexual sex or from mothers to their babies during pregnancy, labor or breast-feeding. For many counselors, the reality that HIV affects not just individuals, but families, is quite salient to them. If the counselors really believe what they have been taught-- that those who know they are HIV positive and are well-counseled will try not to infect others or even more, that pregnant women on treatment will reduce the risk of transmission to their babies—it would be important for them to make every effort to persuade a client to be tested. Thus, counselors may be loath to enforce voluntary testing in its strictest sense.

Malawi's counselors also think about consent differently than the guidelines suggest because they take for granted that families have legitimate claims on their members-- claims which may override individual rights (Izugbara and Undie 2008). In the case below, Harold, a counselor in his mid-30s, describes how a more senior counselor advised him to handle cases in which parents send their children to the clinic to be tested. Not only does Harold empathize with the parents' reason for wanting to know their children's HIV status, he also articulates a different ideological heritage from the individualism of the West: rather than the autonomous individual, Harold emphasizes the importance of the collective as he explains to the daughters why they should accede to their father's demand:

> A fellow, more senior counselor, told Harold about a case he had of two girls—aged 15 and 17—who were sent by their father to the clinic to be tested. Harold explains that the father came first and was non-reactive [HIV negative] and he wanted to know if the virus was 'with us' [in the family]. The other counselor explained to Harold that he might 'get this situation' and 'not to refuse—there may be a reason why they were sent.' Harold explains, '…people want to know because they think like a family. They want to say we are all non-reactive.' He continues that if the girls felt forced to be tested, 'you show expertise on counseling…you might say [to them], your father is thinking of your future.' [Counselor Harold, 2007]

In other cases, however, counselors may have a more personal connection: the client in question may be a relative. In this situation, testing norms may not be adapted, but violated. Martha, a counselor in her mid-50s, explains how she handled the case of her own daughter, whom she suspected might be HIV positive. Martha's daughter was pregnant and had refused to have an HIV test during her antenatal visits. Martha clearly thought her daughter may be infected, and the family, not only the unborn (grand) child, would be affected. She therefore tested her for HIV without her daughter knowing:

> Martha explains that her children all live with her. She was concerned about one daughter who is not married and came home pregnant one day. Martha explains that her daughter refused to get tested during her antenatal visits at the health facility nearest to them (and the one where her mother works) and had insisted on giving birth at the District Hospital instead. When the baby was born, Martha asked the midwife not to dispose the placenta. She took the placenta, and with her hands, delicately illustrates that she tested it herself for HIV. It was then that Martha discovered that her daughter is HIV positive. Martha reasons, 'I've got children and if this daughter of mine does not know her [HIV] status, she can infect us.'[39] [Counselor Martha, 2007]

[39] In two interviews, including the one with Martha, counselors shared stories about testing a mother whose daughter died of AIDS. In both cases, the mother was the primary caretaker for the sick daughter, and cared for her by bathing her and by cleaning her open wounds with bare hands. While it is uncertain whether these two mothers contracted their HIV infection from their daughters, based on the information the clients shared with them, the counselors believe this is how transmission occurred.

Although Martha would have been taught that it is a misconception that HIV can be transmitted by casual, everyday activities such as sharing plates, it seems she is not certain that she herself and her other children might not be infected by the daughter. She also was likely taking into account that there are life-saving medicines available for both her daughter and unborn grandchild; and, since the daughter was not married, when the daughter became sick the family would have the responsibility of paying for medicines and trips to the hospital, as well as caring for the daughter physically. Her concern as a mother clearly trumps those of the ethical mandates of counselor.

In a similar case from the field journals, a client was brought to the health facility, the Tuberculosis (TB) ward specifically, by his uncle-- also a health worker-- for what the client understood to be treatment for a bad skin rash. Once at the clinic, the uncle instructed the health worker at the TB ward to take a sample of his nephew's blood. Thereafter, the nephew goes to see the skin clinician, who tells him, much to his surprise, that his health passbook notes that he is HIV positive and that he can be put on ARVs after his skin problem subsides. Below, the hospital staff-- the skin clinician and two HIV Counselors-- discuss the situation, which clearly broke the proper testing protocol of seeking informed consent:

> After attending to him [the client], Mr. M'phatso, the [skin] clinician, came into the room; this time Sydney [another HIV Counselor] had also come into the room. Mr. M'phatso said if we say that you must follow the counseling protocol, you would have killed that client [the nephew] [080416].

The conversation suggests that the peril of waiting for consent-- according to the clinician, and by implication, the client's uncle-- is that it might have prevented the

client in question from being tested for HIV, and as a corollary, receiving life-saving, antiretroviral treatment.

Counselors also confront cases where an HIV test is ordered for diagnostic purposes by a clinician, such as when the client is suffering from TB or an STI. In these cases, it is the role of the counselor to explain to the client why they are being sent for a test, as many clients are just told by a clinician to get a blood test without further instruction or specification that it is for HIV. Consequently, counselors are placed in tenuous positions that can lead to conflict in the health center, namely when the will of the client is at odds with the order of the clinician. At times, counselors will send clients back to the clinician if they are unwilling to be tested; other times, they accede to the clinician's demand. As Robert, a counselor in his late-20s explains:

> 'With the faith [patients] they have the in the clinician, they just go [for testing].' He adds that in that case, they [counselors] 'just take the client [and test them]. Clinicians [can be] harsh or sometimes your bosses…[In those cases] in your heart you know you can't help the client [to know more about HIV and make his/her own decision to be tested].' [Counselor Robert, 2007]

In this case, while the counselor himself may see the medical benefit of testing, he nonetheless sees his mandate as an HIV Counselor as null and ineffective if he cannot counsel clients about HIV and present to them the opportunity to say "no" to the test.

Confidentiality

> When I asked her what confidentiality means, Agatha replies, 'when you get information from a client and when you give it-- it means not mentioning it to someone else.' Asked if clients understand confidentiality, she says they do, and those who understand say [to the counselor] 'don't say anything.' She adds that those who are illiterate, 'start talking to their friends.'[40] [Counselor Agatha, 2007]

[40] By this, the counselor means that those who have no education tell others their HIV test result.

Officially, confidentiality refers to "…the agreement of the counselor not to share anything that is said or done in the counseling room with anyone else without the express permission of the client" (Ministry of Health [Malawi] 2007b: 73). Of the three testing norms, confidentiality is perhaps the most troubling for the counselors. They can all recite what they have been told about confidentiality in their training, and in the interviews they all present themselves as sticking to the letter of this guideline and most to the spirit as well. But it clearly bothers them. Chaka, a counselor in his early 50s, explains:

> 'This confidentiality is not helping on my side [in my opinion].' Chaka explains that sometimes a man comes in for a test, finds out he is HIV positive and then continues having sex with other women. 'This, to me, it breaks my heart.' He adds that it could be better if people could know the status of others. He continues that he does not know why confidentiality is emphasized so much in training and explains that he once tried to bring up the problems with confidentiality, but it was 'brushed off by some clever people.'[41] [Counselor Chaka, 2007]

Mary, a counselor in her early 40s, articulates a similar sentiment. She recalls a son deeply concerned about the HIV status of his mother. Mary, however, was unable to disclose the mother's test result to her son, placing her in a moral quandary:

> Mary asked the mother to whom she would share her results and she said no one, despite her efforts to convince her to do so. When the mother exited the counseling room, the client's son approached her and wanted to know his mother's test results. Mary explained to him, 'I don't have the mandate [to tell you].' The son was very disappointed, but she told him it is 'against our ethics [to disclose results].' Mary referred the mother for a CD4 count at the District Hospital. She continues, 'I knew he [the son] would know then [that his mother was HIV positive].' [Counselor Mary, 2007]

[41] By this, the counselor means that it was a request ignored by educated elites, like the CTE, who have influence on testing policies and procedures.

Later in the conversation, Mary reflects on the same case:

> 'It is very difficult…Sometimes I feel very bad because I'm not telling him [the son] what is there and it is a risk to this person…This is a problem we have as counselors-- at the same time we have to keep confidentiality, we put others at risk. We are left with a dilemma.' [Counselor Mary, 2007]

The core reason that confidentiality troubles the counselors is that they think it is not good public health practice: it impedes, rather than facilitates, the prevention of harm. In the communities of rural Malawi, strict abstinence or fidelity is considered by many to be extremely difficult, if not impossible: thus, partner reduction and careful partner selection are considered as particularly attractive alternative strategies of HIV prevention (Reniers 2008; Watkins 2004). Yet if you do not know someone is HIV positive you might unwittingly put yourself at risk if you are married, if you propose marriage or a partnership, or if you accept those proposals. Thus, to many community members and counselors alike, public disclosure of HIV status would contribute to HIV prevention. The pressure for at least limited disclosure may be particularly strong in rural communities, where the village and its surrounding areas serve as the marriage and partnership market, and where HIV Counselors, who live there, may well know whose sexual partner is HIV positive.

Even if counselors have been posted from elsewhere, they quickly settle in and make friends, or they may have a relative already living there. Aaron, a counselor in his mid-20s, explains that he frequently fields inquiries from his buddies about who among the local women is a suitable partner. In a boyish encounter on the soccer field, Aaron nimbly deflects one friend's queries about the town's young women:

> ‘You [Aaron] and me [friend], we are both unmarried,’ suggesting that they might both be vying for the same women. The friend asked Aaron to tell him which girls he thought were ‘good ones.’ Aaron explained to his friend, ‘Brother I can’t, it’s against my principles.’ He continued that he told him that he should go for VCT and have his girlfriends get tested too. When asked if a friend ever inquired of him about the HIV status of a particular girl, he laughs as if this is common: ‘I tell them that they have to ask [the girl].’ [Counselor Aaron, 2007]

Donna, a counselor in her mid-30s who has tested returning soldiers for HIV, explains that women in her village frequently ask her the test results of their husbands. They say to her:

> ‘We are going to die soon [if you don’t tell us].’ She explains that they are testing her because they want to know ‘If I am telling everyone [about their husbands test results].’ [Counselor Donna, 2007]

While counselors are trained to encourage clients to disclose their HIV status to someone they trust, they often fear being blamed for lack of reticence when individuals share their test results with others. As Robert, a counselor in his late-20s explains:

> ‘Clients, I think they understand [what confidentiality is], but they do not want to admit they understand, or that it is true…[When] people share results, others think that it is the counselor that does not keep secrets.’ [Counselor Robert, 2007]

In the field journals, Sekou notes the case of a daughter who brought her mother to the hospital to be tested for HIV. The mother had been sick for weeks, her condition undiagnosed, and the family was concerned. Both the mother and the daughter were surprised when they arrived at the health facility because they knew Sekou, the counselor. Sekou asked the mother if she was comfortable having her daughter present while she was tested and the mother replied yes, assuredly. Later, however, after disclosing to them that the mother is HIV positive, Sekou reflects:

> I was left pondering on what would happen if the daughter would tell the results to other people not sanctioned by her mother. Obviously the mother will assume that it was me who has broken the news to other people. [090102]

Counselors clearly have access to this coveted information about clients. And in some cases, they may exploit it. In an example from the field journals, an HIV Counselor was caught by his superiors asking his female clients who tested HIV negative to return periodically to be re-tested. Given the fear in Malawi that one's HIV status will hurt his or her marriage prospects (Kaler and Watkins 2010), it is reasonable to assume that it is not enough to simply ask someone their HIV status. Indeed, those who have been tested may be loath to disclose truthfully if they are HIV positive. Monitoring it yourself, therefore, may be a rational option:

> He [HTC Supervisor] then said a certain counselor is proposing [making advances to] women who he finds to be HIV negative by giving them unnecessary review dates [dates to return for testing] so that he will be able to advance his agenda. He continued saying that the said counselor at one time had booked a married woman for review. Unfortunately he did not know that the woman's husband is also a health worker. And when the man asked his wife how come she has to go for review at VCT every week when a person is supposed to go for a retest after 3 months, the woman said it is the counselor who had advised her to visit [go for] VCT for further consultations. The man then told his wife that they will go together on the said review date. When the date was due the man and his wife set off to the VCT clinic and when their turn came they told the counselor that they had come as a couple for counseling. The counselor was shocked because the woman told her husband that the counselor had always insisted that when coming to the clinic she should be alone. [080401]

Counselors may also empathize deeply with families who will have to care for individuals who are HIV positive; they may also want to ensure that those who are HIV positive receive the care from their families that they need. Counselors faced with this situation may search for ways to preserve the sanctity of confidentiality, but also reduce

the danger that keeping quiet may pose to others. As Chaka explains, 'They [in training] tell us no [you cannot say anything to someone else], but with experience you know what to do, you cannot just leave it like that' [Counselor Chaka, 2007].

One way counselors may handle this dilemma is by assuming the moral authority to intervene directly, following the letter but not the spirit of their obligation to confidentiality (also see Datye et al. 2006). Later in the conversation, Chaka explains how he handled the case of his neighbor, whose son had tested positive for HIV:

> The son of his neighbor had come in for a test and was found HIV positive. Chaka explains that he went and persuaded the parents to ask their son about his HIV status. The son was angry and said to Chaka, 'You told my parents [that I'm HIV positive]!' But Chaka then said to him, 'Did I? Go and ask your parents.' Chaka explains that in these situations, you have to find ways to deal with the problem and this was not dealt with in training. [Counselor Chaka, 2007]

Sometimes it is at the *request* of clients that counselors assume an extra-clinic role and disclose a person's HIV test results to the family. Felix, a counselor in his mid-20s, describes the case of a friend who tested HIV positive and did not want to share his results with his family himself. Felix clearly sees his role as counseling not only his friend (the client), but also his friend's family members:

> 'As far as ethics it is not hard [to maintain confidentiality]—it is our duty to maintain secrets.' In reality, he admits, it is difficult, especially in the case of a brother or sister. Felix said he had an example of a friend who was found reactive [HIV positive] and wanted Felix to tell his family so that they could understand and assist him. He said that he was then relieved when the friend asked him to go to his village with him and to tell everyone about his status. Felix said he first told the friend's parents. He said they had some doubts when he told them, because they did not think it could fit with their son's behavior. Felix adds that he could also counsel the family about how to take care of their son. [Counselor Felix, 2007]

In training, counselors are taught that if they are confronted with a situation where someone they know might unknowingly be exposed to HIV, they should *encourage* them, and have them encourage those who might have infected them to be tested, without disclosing the status of the infected partner. This strategy, however, may prove too little too late. One journal captures a conversation among a group of off-duty HIV Counselors, who are discussing the recent case of a woman who was hiding her antiretroviral medications-- and by extension, her HIV status-- from her husband (also see Smith and Mbakwem 2010). Given the risk that this situation posed to her husband, the counselors debate the ethics of the confidentiality clause. Not only do they reject it, they also mention their willingness to protect the members of their family from the risk of HIV infection over saving their own credentials:

> Arnie told a story of his neighbour who has married a woman who is already on ART. The man had gone for HTC before he got married and when he met the woman [she] also told him that she had HTC done already. The man believed the woman and they got married. Currently the woman is still receiving ART but the man doesn't know. Then Tonya asked, 'what is the use of confidentiality when it will promote the spread of the virus and later have people die?' Jeremiah then said as counselors we need to gang up and organize a march to enlighten the policy makers that another barrier to the fight against HIV and AIDS is the issue of confidentiality. Other counselors said, 'we second the motion, let it pass...' One lady counselor said, 'as for me if it happens that my sister or brother's partner has been found with HIV, I will risk my job by telling her that your partner has HIV. If I lose my job and they recall my certificate, I can find another career.' [080601]

Counseling

> When I asked how much clients know about HIV, Ruthie said that now 'They know a lot because we teach them, and they go home and explain to others.' She said that before they come, they are afraid, but 'When we explain the details, they understand.' [Counselor Ruthie, 2007]

Officially, counseling takes place twice during the HIV Testing session: before the administration of the HIV test ("pre-test" counseling) and after the test results are given ("post-test" counseling), when counselors discuss with clients how to take appropriate care of themselves if they are HIV positive and how to avoid infection if they are HIV negative (Ministry of Health [Malawi] 2004). Counseling's stated goals are to: 1) "encourage the client to become self-reliant and feel confident about his/her own ability to make decisions"; 2) "help a client feel better or at least more comfortable particularly in the long run"; and 3) "help a client to become more self-sufficient to deal with on-going and future life situations in a constructive way without requiring continual help" (Ministry of Health [Malawi] 2007b: 62).

What can be accomplished in the clinic as far as counseling is concerned, however, is often limited. Several structural considerations, for example, impede following mandated counseling procedures: both adequate space and time may be scarce, given the volume of other, perhaps sicker, patients. One way this is handled by counselors-- and endorsed officially by the CTE as an option, particularly in busy test sites--- is by conducting pre-test counseling with a group of clients, rather than individually, and by keeping the focus on general information about HIV (Ministry of Health [Malawi] 2007b). This option may be more often the norm than the exception.

However, such group counseling may be insufficient in terms of what clients actually want and need and how counselors respond to them as a consequence. In practice, counselors counsel not only in the clinic, where it is mandated formally, but also outside of it. Counselors mentioned visiting clients in their homes, or receiving

visitors who had come to their home to ask about the HIV status of their partners, or with questions about their own risk for HIV. Gertrude, well known by those in her village, conducted *pre*-test counseling in her home for those who showed up at her door requesting it. She is sensitive to the concerns of her visitors, namely the fear of being seen at a local health facility by others who might question motivations for testing (Angotti et al. 2009). Gertrude's home affords a place of convenience, privacy and familiarity to discuss HIV:

> 'I have many clients who say I have saved their lives…they even come to my house.' Gertrude explains that clients say they don't want people they know to see them going for VCT. She continues that she has had five couples and two individuals visit her at her home at different times. She counseled them in her bedroom, because her husband passed away, and tested them at the hospital. She explains that she knew the clients beforehand: 'Some are my neighbors and others we pray at church together.' [Counselor Gertrude, 2007]

In other cases, *post*-test counseling may occur outside the clinic setting. Simone, a counselor in her late-20s, shares a story about a close friend who comes to the health center to be tested for HIV. The friend was worried that her boyfriend, who refused to use condoms correctly, had infected her with HIV. After Simone tests her, and the friend learns that she is indeed HIV positive, the counselor makes regular visits to her home to follow-up:

> Simone says that she has visited her friend since her HIV diagnosis because her friend 'wants to share [religious] ideas.' She explains, 'She is my friend, I can't just leave her.' She continues that her friend has shared her HIV test results with her mother and father and that the parents have asked that Simone visit their daughter regularly to remove her worries. [Counselor Simone, 2007]

According to official guidelines, counselors are not to counsel clients with whom they have had a sexual relationship or with whom they have a current personal

relationship (Ministry of Health [Malawi] 2007b: 260). However, it is clear that in tightly-knit rural communities, and in settings where there is a dearth of health workers, this guideline is highly improbable. Hence, it is often not just the role of HIV Counselor with which counselors contend, but also a competing role, such as a friend, fellow Christian, village elder or neighbor. As a corollary, counseling, as adapted by counselors, is not a bounded entity that occurs only in the clinic setting before and after the administration of the HIV test. Rather, it is something they flexibly adapt as the needs of clients--and as the roles and responsibilities incumbent on counselors in their extra-professional lives--dictate.

Clients are also well aware that they may need extra help from health personnel, a type of assistance that is not included in official counseling and testing guidelines. As previously illustrated, there are several cases of clients, or their family members, actively seeking help from counselors outside the clinic setting. Oftentimes, the situations are grave. In an example from the journals, a pastor had his wife send a message to Sekou requesting that Sekou visit him in his home. The pastor was quite ill—too ill, he explained, to wait on the long line he encountered at the hospital to get his ARV medication. But he wanted to be helped. Sekou explains:

> When I reached his house I found that he was sleeping at [in] the sitting room and when I greeted him he told me that he was not feeling well because he had vomited the previous night and now he was weak. He managed to sit up…He showed me his health passbook where the test results were stapled. His CD4 count was below 250; it was at 231 to be precise. Immediately I advised him that at that CD4 count of 231 he was eligible to start ART. He then told me that he had gone to the ART clinic but there were a lot of people and since he was not feeling well he decided that he will have to go there another day. I told him that if he will be feeling better he can make a date with me on Friday so that I can

> assist him, book for ART Group Counseling and enable him to access the ARVs.... [080421]

In another example from the field journals, a man very sick with AIDS travels to the home of Mr. Nyirema, a health worker, after returning from the hospital to get his ARV medication. He leaves a note with Mr. Nyirema to share with Sekou, whom the client was unable to locate at the hospital. The client knows Sekou personally because they had both been members of the same church choir. His note explains that he is very sick and has no money to buy food. Sekou and Mr. Nyirema decide to make a trip to the client's home, bring him something to eat, and console him. They also meet with his wife and talk to her about how to best care for her sick husband:

> When Mr. Cuzco [the client] saw us he started crying … 'I never expected that you would come, I am in [have] problems.' Mr. Nyirema told me to go and help him walk to where we had sat and I did so. He walked with some difficulties because he was weak...We encouraged him never to lose hope and give up because he has a very big life ahead of him. We told him that we came because we knew that he is our friend and brother regardless of his HIV status.
>
> We asked him what he had taken [eaten] that morning. He said he had not taken anything apart from the ARV pill for [in] the morning. Mr. Nyirema then advised him that it is not good to stay hungry while he is on medication. He told Mr. Cuzco that he should ask his wife to cook porridge for him every morning and if there is groundnuts flour she should add [it] to the porridge. Mr. Cuzco agreed and said his wife left early in the morning because he has developed a hernia and wanted [was looking for] transport to take him to the hospital.
>
> After waiting for an hour and his wife was nowhere to be seen, we started off [on] our journey. As we were about to reach the main road from the village we met two women who stopped us. I realized that the woman who was stopping me was Mrs. Cuzco…We explained to her why we had come and told her that she should make sure that Mr. Cuzco is given some food everyday…while he is taking ARVs. [080421]

DISCUSSION

This chapter examined the ways in which HIV Testing's "3Cs" (consent, confidentiality and counseling) are adapted by their implementers to local concerns. As stipulated by policy guidelines developed in Geneva and by the CTE in Malawi, HIV Testing is intended to include counseling and be conducted with informed consent; all matters discussed between the counselor and client, including the test result, are supposed to be confidential. In rural Malawi, however, the implementation of Western testing norms is, at times, quite different from that envisaged in official policy. The protocols that HIV Counselors are taught does not—and cannot—cover all contingencies: what counselors do in practice is necessarily discretionary (Carter 2008; Pritchett and Woolcock 2004). As these intermediaries implement the policies of consent, confidentiality and counseling-- policies that they themselves have not designed, had their origin far from rural sub-Saharan Africa, and are doubtless dynamic in the current therapeutic and institutional environment for testing in Malawi-- they thus actively interpret and reframe them (Booth 2004). In most cases counselors' adaptations of testing guidelines are minor; in other, rarer cases, their adaptations are extreme. These are cases where the ethics of HIV Testing come in conflict with the desire of the counselor to behave in a way that is consistent with his or her sense of morality.

So how do they adapt testing guidelines and why do they do it? Perhaps the most significant reason is that HIV Counselors in rural Malawi are deeply embedded in the communities in which they live and work. As such, distinguishing between their role as a HIV Counselor and the competing roles they occupy in their extra-professional lives--

be it as a concerned friend, a fellow Christian, a village neighbor-- is clearly quite difficult for them, as the nature of interaction in rural African societies is characterized by face-to-face relations where people often know each other or one's family (Weinreb 2006). From this perspective we can see that their adaptations are not acts of malfeasance, but rather responses to the moral quandaries that the exigencies of their jobs impose. Another important reason is that strictly abiding by testing guidelines often contradicts what they take seriously as their mission: to help those whom they were trained to protect. Indeed, counselors are often quite responsive to the needs of their clients, whose specific cases, questions and concerns inform the testing encounter (also see Joffe 1986). This is particularly so in cases when clients are already quite sick and counselors think they should be tested for their own good, and/or when they feel that those who will shoulder the responsibility of caring for them should be informed of their (positive) HIV status. In such cases, counselors perceive official procedures as impeding, rather than facilitating HIV prevention, as doing harm rather than good. To resolve this dilemma in a way that permits them to see themselves as a moral member of their community, counselors distinguish between the office (health facility) and outside the office, where their real work as missionaries of public health can continue. This work is varied and indeed personalized: it may include intervening in clients' family lives, praying with those who are recently diagnosed, or delivering food to those who are sick.

In the next chapter, I consider how villagers, the intended beneficiaries of testing programs, experience the policies and programs advanced by the CTE and implemented by its front line workers, HIV Counselors.

Chapter 4
Villagers: A View from Below

As I walk along the main road in Matinda village, women dressed in colorful chitenjes earnestly flag my attention to their bananas, sweet potatoes and plump red tomatoes, stacked perfectly in the shape of pyramids. I eventually stop to purchase a soft drink at a small hut with a grass-thatched roof under which two men were drinking chibuku, a locally brewed beer, out of brown paper bags. They are in their late-20s and reclining on blue plastic chairs. The more talkative one of the two was light-skinned and had a striking pair of ears, the tops of which formed the shape of triangles. He is flirtatious, though innocuously so, and invites me to join them for a chibuku. I graciously decline and continue on my way.

Kondwani arrives about an hour later to find me. He enters a local canteen adjacent to the summer hut. The owner was busy stacking the one small refrigerator with soda bottles. Kondwani buys a bottle of Coca-Cola and joins a small group of men, also inside, chatting casually over Sobo ginger ales. They all sit on chairs and crates of Coca-Cola in a circle, taking the shape of the dim room. Over the course of the conversation, the men chat jovially about many things-- elements of a good life, sex and marriage, and that which may threaten it, HIV. In the excerpt below, they talk about a notorious HIV Counselor:

> Man #1: For example you go for a [HIV] test [at the health center] and you meet [as your counselor] Mr. Rodney Bula… [laughs] and [Man #2 says] that's what I have just said...[and before he could finish his statement]
>
> Man #1: [Laughs some more and says] By the end of the day, the news will be all over Matinda [their village] [All laugh].

> Man #3:…What is his [the VCT counselor's] behavior like? Does he drink beer? When he is drunk how [does] he speak? [Man #1 adds] Yes, how much does he speak? [Man #3 continues] Does he speak about things happening at his work place [the health center] or things happening at a beer place only? [Men_fgd_#1, 2009].

The following day, Kondwani and I visit the local health center in Matinda to meet with the HIV Counselors. En route, we encounter Ellen, the Head Matron at the Matinda Health Centre, walking along the roadside. She is dressed in a white nurse's uniform with narrow red trim and a matching cap. She flags down our car indicating that she would like a lift to work. We pull over and she enters our car. We make our way off the road and onto a dusty, bumpy one, where the health center is a few hundred meters away. When we arrive, Ellen walks us through the small facility, drawing our attention to signs boasting its marked success in numbers of child immunizations and pregnant women tested for HIV. She then leads me to the HIV Counseling and Testing room, a light gray door on which a sign is displayed, "H.T.C. Moyezetsera Magazi Muno" [Blood Testing Here].

As she and I chat, a young man enters the HTC room through the back door. Ellen greets him and tells me he is one of the HIV Counselors on staff. I immediately recognize his triangle-shaped ears. He and I exchange glances; it is obvious to each of us that we have already met, the previous day under the thatched hut. I am careful to avoid mentioning the circumstances of how we met in front of the Head Matron, who might have disapproved of his daytime chibuku consumption, especially if taking place during

working hours. He introduces himself to me, formally this time, as Mr. Rodney Bula, the man mentioned in the conversation over sodas in the local canteen.

By way of a series of small coincidences, the encounters above illustrate the small world that is rural Malawi. More fundamentally, it suggests that (imported) testing norms, in this case confidentiality, enter a social world monitored carefully by those who inhabit it. In matters of HIV, this close monitoring may include observing who is going for an HIV test, as well as their faces when they exit the testing room (Angotti et al. 2009; Yoder and Matinga 2004); relying upon a stock of common knowledge to speculate who might be HIV positive based on one's symptoms, appearances or behaviors (Santow, Bracher, and Watkins 2008; Watkins 2004); or, as the opening field note suggests, observing the drinking behaviors of HIV Counselors as an indication of which health personnel can be trusted.[42]

In this chapter, I consider how villagers, the intended beneficiaries of the efforts of the Counseling and Testing Establishment (CTE) and of its foot-soldiers, the HIV Counselors, experience HIV Testing. HIV Testing's "3Cs"—consent, confidentiality and counseling-- are touted officially on both public health and human rights grounds: it is said that when it is voluntary, individuals are more oriented towards behavior change;

[42] A respondent from the CTE shared a reported case of a counselor who went on a drinking spree, encountered a man he recently tested positive for HIV, and asked him for money for a beer. When the man said no, the counselor replied, 'you are dead anyway' [Government representative_#14, 2009]. In a case from the field journals, Sekou describes his colleague Fredrick, who was rumored to tell people's test results when he is drunk or has a quarrel with the client outside the test center [080421]. And, a Village Headman explained that members of his village complained to him about an HIV Counselor who was disclosing people's test results while he was drinking at beer joints. The Headman filed a complaint about this counselor with the Medical Officer in charge of the facility where the counselor worked [Headman N, 2009]. While these stories may be dismissed as anecdotal, they are nonetheless what people remember, and may doubtless affect how people weigh a decision to be tested, where to be tested, and by whom.

when it is confidential, it reduces threats of stigma and discrimination; and when there is counseling, individuals will make wiser decisions to avoid putting themselves at risk for HIV or giving it to others, and can be referred to a clinician for treatment if infected (UNAIDS 2001). But is this how rural Malawian men and women, the targets of the efforts of the CTE, see and experience HIV Testing?

As this story of HIV Testing moves from international headquarters, through capital cities, to villages that span Malawi's rural landscape, the "3Cs" take on new forms and meanings. Far from openly embraced, they often stir conflict and contestation-- in marriages, in families, in communities, and in health facilities-- consequences largely unforeseen by the champions of individual rights and ethics in matters of testing.

VILLAGERS

For rural Malawian men and women, life is insecure and uncertain: death is ubiquitous, subsistence livelihoods are tied to the vagaries of the weather and fertilizer subsidies, and in the absence of a formal labor market and safety nets, patron-client relations are strong (Swidler and Watkins 2009). In trying to make of so much uncertainty, occult explanations often prevail (also see Ashforth 2005; Whyte 1997). Deaths from AIDS have doubtless provoked new types of uncertainties (Ashforth and Watkins 2009; Watkins 2004), as has the availability of HIV Testing and the frequent public admonishments to "know your status." At present, rural Malawians are of "two minds" about testing, unlike the CTE and HIV Counselors, who subscribe to the global view of testing as essential in combating the epidemic.

Rural Malawians certainly do not believe that testing is essential for themselves. Perhaps the greatest source of reluctance to be tested is that they believe that they are already HIV positive and either see no need to have this confirmed by a test, or are anxious about a test that would, they believe, close off any possibility that they were not infected (Kaler and Watkins 2010). Many of those who believe they are infected are, however, wrong.[43] It is against this anxiety that villagers views of consent, confidentiality and counseling ("3Cs") is perhaps best understood.

Table 4.1. 2004 MDICP Self-Assessed Likelihood of Current HIV Infection

	Men N=814	**Women** N=1123
	Percentages	
HIV Prevalence	7.4	7.8
Self-Assessed Likelihood of Current Infection		
No Likelihood	61	51
Some Likelihood	27	34
Don't Know	12	15

Source: Angelwicz and Kohler 2006

In the sections that follow, I consider the local reception of HIV Testing's core tenets—consent, confidentiality and counseling--- at the village level from the perspective of rural Malawian men and women. I draw upon various data sources,

[43] Survey data from the MDICP, whose sample characteristics are similar to those of the nationally representative rural population interviewed by the Malawi Demographic and Health Surveys, revealed a gap between the proportion who consider themselves to have some likelihood of infection (27% of men and 34% of women) and the proportion of those who actually were infected (7% of men and 8% of women). An analysis of this gap showed that respondents vastly overestimated infectiousness of the virus (Angelwicz and Kohler 2006; Santow, Bracher, and Watkins 2008).

including interviews with Village Headmen, interviews with individuals tested for HIV, focus group discussions, observational field journals and participant observation.[44]

Consent

The CTE promotes consent for HIV Testing as a matter of informed choice. The public health rationale is that those who test against their will are not motivated towards behavior change, a purported aim of testing as a prevention measure for HIV despite the dearth of empirical evidence that shows that learning one's serostatus changes one's risk behavior (Obermeyer and Osborn 2007; Yeatman 2007). The idea of volitional testing is predicated on the human rights ideal that individuals have sole authority over their bodies and accordingly, will act in their own best interest to learn their HIV status.

The story coming from rural villages in Malawi, however, is quite different from that envisaged officially. The "decision" to be tested and, as a corollary, the exercise of consent, is much more complex, suggesting that effective social action is located in social relationships, not in the privacy of people's minds (Emirbayer 1997; Pescosolido 1992; Tilly 2005). Collective rights rival individual rights in rural Malawi (also see Izugbara and Undie 2008), a setting where families have powerful claims over other family members, where Village Headmen serve as the highest form of local authority, and where health providers are often seen as experts to whom one should defer if one expects to be helped.

[44] Though I include Village Headmen in this chapter, I recognize that they are intermediaries between international actors and members of their communities, which may thus warrant their separate treatment as an independent set of actors. Indeed, as this chapter will show, headmen may use their power for the HIV-testing cause. As such however, their placement in this chapter illustrates the normative pressures with which villagers make decisions about testing. It is also important to note that, as Dionne (2010) finds, headmens' policy preferences as it regards HIV/AIDS interventions are, on average, more closely aligned with villagers than external actors.

In an analysis of a sample of 30 rural Malawian men and women tested for HIV in three rural health facilities (a government district hospital, a private hospital and a local public clinic), the majority were tested during the course of antenatal care (43%), because they were sick (33%), or "to know my status" (23%).[45] That the overwhelming majority were tested either because they were pregnant or ill is not surprising. On one hand, the distance to reach a health facility involves direct and opportunity costs for both the individual, and at times, his/her family caregiver. Thus, for many, the opportunity to learn one's HIV status is not a sufficient incentive to pay these costs (Angotti et al. 2009). On the other hand, routine testing policies for antenatal and diagnostic purposes shifts the initiative from the individual to the provider. While individuals must still provide consent to be tested, how rural Malawians perceive that option (if indeed actually provided) may be different from that envisaged in Lilongwe offices or in documents produced in Geneva.

The overwhelming majority of respondents tested for HIV during the course of antenatal care, for example, explained that they had no option to decline the test.[46] One woman's remarks capture the typical experience:

> Respondent: No, he [the HIV Counselor] told us to be tested.
>
> Interviewer: Did he give a chance to you that anyone who wants to be tested can do so and anyone who doesn't want cannot be tested?

[45] "To know your status" is the language of social marketing and used in many HIV testing campaigns in the region. While respondents did not necessarily mention 'to know their status' explicitly as a reason for testing , and interviewers were instructed to probe further if this was the response provided, this category captures those for whom testing was meant to alleviate some form of uncertainty about one's HIV status, the details of which will be explored in the actual text.

[46] It is important to note, however, that the HIV client sample was drawn from individuals tested for HIV, thereby excluding those who may have refused testing.

> Respondent: No he did not give us that chance.
>
> Interviewer: Okay. Why do you think that you were not given that chance?
>
> Respondent: Because it is important for women to be tested. [Client_#10, 2007]

Perceptions among villagers in the focus group discussions corroborate this perceived mandatory testing requirement for pregnant women. In all five focus groups, rural Malawian men and women stated that pregnant women will be tested for HIV as a routine part of their antenatal care visits; and, in two focus groups, participants mentioned that women will be HIV-tested, "whether you [the woman] like it or not" [Mixed_fgd_#2, 2009; Mixed_fgd_#3, 2009]. One woman described the testing process during the course of antenatal care in detail:

> Women #2: Now it's mandatory. At the hospital it is such that if you want antenatal services, [HIV] blood test then the ticket and cotton on your hand showing that you have been pricked is your ticket for antenatal clinic. No ticket, no services. They enlighten you first on the goodness of blood test for child to be born because you are preparing the baby's future… [Mixed_fgd_#1, 2009]

The consequence of the perception that testing is a mandatory prerequisite for antenatal care is that some women who would otherwise get antenatal care do not (Angotti, Dionne, and Gaydosh 2010), findings that are consistent with perceptions among a few members of the CTE about what is currently happening in health facilities (Chapter 2) as well as by comments made by HIV Counselors (Chapter 3). In the field journals, Sekou describes a case of a pregnant woman who comes to the counseling room for an HIV test upon the insistence of one of the hospital's nurses. The woman's

encounter with the nurse shows that if she were to refuse the test, she would not be able to receive antenatal services:

> Whilst I was working suddenly a pregnant woman opened the door…I enquired from her what assistance she needed from the [VCT] center. She smiled lightly and said, I came to the antenatal clinic and the nurse has asked me to come for an HIV test…The woman said she has come because the nurse has told her that if she doesn't go for an HIV test she should not come back to the antenatal clinic the next visit…. I asked her if the nurse had explained to her the importance of the test results to her and unborn baby which she was expecting. The woman said that the nurse told [said], 'Go to the VCT to know your HIV status whether you will cry is none of my business. If you don't go there never come back here.' [081201]

Notably, there is an expressed sentiment among many that testing by "force" is necessary and justified. Pregnant women tested for HIV, for example, spoke favorably of having been tested, perceiving it as the best option for the mother and her unborn child (Angotti, Dionne, and Gaydosh 2010). As one woman in a focus group discussion stated, and which her friends (also participating) echo: *"*If people are not forced [to be tested] then there will be no one who will remain alive. We will all die" [Women_fgd_#1, 2009]. For women who wish not to be tested, it is perceived locally as either suspicion she is already HIV positive and thus has something to hide, or as a disregard for the health of the child. As one woman explains of her own experience being tested:

> Woman #3: …I got tested together with three other women. After we gave blood for testing and it was time to get results, I went inside to get my test results and found that the other woman--we got tested together--just sat outside. So when they called for number 52 she was quiet and I said, "It is this one." She then ran away.

> Woman #2: It means she was suspecting that she is infected.
>
> Woman #3: Yes she was afraid that she is infected. She reached the doorway and we told her to get in, she turned and went back [home] and she failed to go for antenatal service…
>
> Other women: Aarrh….. Are you sure? [Women talk in random order] That's not good running away from the hospital. It's good to get tested for HIV. Yes Yes. You know your status, yes… yes…and you do your chores with peace and mind. This is where you have mother is sick, baby sick without anyone being at rest. Is that good life?
>
> All Women: No, No. [Women_fgd_#1, 2009]

But it is not only with health workers and gossiping neighbors that women, specifically pregnant women, have to contend: consent for an HIV test also often hinges on her husband's approval (Angotti, Dionne, and Gaydosh 2010). Rural Malawian men and women noted that there are husbands who object to their wives being tested, though such objections are largely frowned upon, even by some men:

> Facilitator: What if her husband doesn't want her to have the test?
>
> Man#1: Reaching at that decision, man shows that he does not love wife, kills the wife's future. Husband does not know who between the two has the virus. It's clear that when it comes to this disease [AIDS] men are number one suspects but women can also transmit the same to men. As such a man should not have this idea of denying the wife to go to the antenatal clinic because he already knows what happens there [that she will be tested]. There should be love between husband and wife and he should wish better life for the wife and the child to come.

> Man #2 Mmm let us look at this clearly [clears throat]. Where is this husband when he is refusing the wife to go for antenatal? At home or at the clinic? It's not possible for a man to refuse the wife to have a blood test while they are together at the clinic. That cannot happen but what I know is if the wife refused to go whilst at home, so if the husband emphasizes that she should not go, she will not dare to even go to the antenatal clinic. She will listen to the husband. Like I said before if there is adequate information that this lady is not going for antenatal care because of husband, there is need for health workers to call for the husband and talk to him nicely. [Mixed_fgd_#1, 2009]

It is with good reason that men may fear their wives being tested: many men believe that if their wives return with a positive test result, this means that they too are HIV positive-- that is, if your wife has HIV, you are also certainly HIV positive. This interpretation is consistent with other work which suggests that people tend to greatly overestimate the transmissibility of HIV and assume that everyone who has sex with someone who is HIV positive will themselves get AIDS (Angelwicz and Kohler 2006; Santow, Bracher, and Watkins 2008):

> Man #2: Maybe the husband does not trust the VCT counselor and is scared that if the wife gets tested and learns she is HIV positive then the husband will also know that he too is positive so in this case he may say 'Don't get tested.' [Mixed_fgd_#1, 2009]

Even men who would themselves choose to be tested may not want to be informed of their diagnosis by their wife. Consequently, people may avoid going to government hospitals during the course of antenatal care to evade what they perceive as a mandatory testing requirement (Angotti, Dionne, and Gaydosh 2010; also see Weiser et al. 2006 for Botswana). This was a subject featured in a newspaper article from *The Nation*, "Pregnant women shun hospital fearing HIV test, pregnant women complain"

(Kumwenda 2006), seen in Chapter 2. Thus for many expectant mothers, testing for HIV may represent a "damned if you do, damned if you don't" conundrum: agreeing to be tested may mean conflict with her husband, but refusing may mean she is denied antenatal care, as well as facing the scorn of other pregnant women and health workers who see her as willfully disregarding the health of her unborn child.

But while husbands may exert power or influence over their wives when it comes to testing, rural Malawian women are not without agency, or as Tawfik and Watkins name it, they are not "poor, powerless and passionless" (2007: 1090). As one woman asserts, "We are looking at my life [with antenatal testing], not his" [Mixed_fgd_#2, 2009]. Other women said they would refuse to have sex with their husbands until they themselves are tested: he can "look for another woman" [Women_fgd_#1, 2009] (also see Schatz 2005). Or in a case explained to me by Chaka, an HIV Counselor, some women have come to him to be tested a couple of months before their antenatal visit so that they know their HIV status before their husbands accompany them to the clinic [Counselor Chaka, 2007]. Malawian women, well aware of the popular perception of the dominance of men, may also use their husbands as an excuse to avoid testing: both HIV Counselors and clients stated in interviews those not wishing to be tested during their antenatal visits said they must first ask for their husbands' permission.

In the field journals, Sekou writes about a case of an HIV positive woman who was tested during the course of antenatal care and returned to the clinic for her antiretroviral medication with her husband, whom she had designated as her "treatment

partner."[47] While at the hospital, the clinician recommends to the husband that he also be tested for HIV. The husband, angered by the mention of it, refuses to do so, despite the relentless efforts of the hospital staff to convince him that it is in his best interest. He eventually succumbs, but not without first arguing with the hospital's health workers about his understanding of "rights." The journal excerpt begins with Sekou's summary of what he had been told about the case:

> When the couple arrived at the ART clinic, the attendant thanked the husband for coming and briefed him on his role as a [ART] guardian and also suggested to him that he should also have an HIV test. Immediately after learning about this the husband protested saying he did not come for that purpose, instead he came to escort his wife to get drugs and he did not expect what the attendant told him… He told the attendant that if he is not interested in giving the drugs to his wife he should just say so other than telling him the nonsense of getting an HIV test. He further shouted at his wife why she had come for an HIV test without his consent and also lambasted the health personnel why they allow married women to have an HIV test without the approval of their husbands. He said all this is nonsense and abuse of their marriage rights….

The attendant then brings the couple to Sekou:

> When they entered before I could even say a word the man started talking saying…'brother these days things have changed everybody has his/her rights, you cannot force anyone to have an HIV test. Doing so will be an abuse of someone's rights.' I agreed with him and told him that much as he has his right he also has a responsibility not to interfere with other people's rights while he is exercising his freedom.... [090102]

Many health centers are actively trying to get men to be tested for HIV, as illustrated above, and also by asking women to have their husbands accompany them to the antenatal clinic, as described by an HIV Counselor in the previous chapter (Chapter 3). One way in which rural health centers have addressed this issue is by appealing to

[47] Enrolling on ART requires that HIV positive individuals choose someone to accompany them to the clinic for counseling on how to take the medication.

Village Headmen -- the highest form of local authority—for assistance. One headman explained that the hospital sent him a letter advising him that men are supposed to accompany their wives for testing [Headman S, 2009]. Another headman innovated: he tells us of a meeting which he attended organized by hospital officials where the staff brought to his attention that men in his village were not showing up with their wives for testing during their antenatal visits. He thus develops his own tracking system, one alongside a register he uses for the distribution of fertilizer subsidies. The headman explains:

> This morning I noticed pregnant women amongst the people who had come [to me] for fertilizer coupons discussions. I called for them and asked them whether they have gone to the hospital with their husbands. They said no and I told their husbands that they need to do so. What happens is that when people go for antenatal clinic and they are tested there I record in my book. I have a book with names of all people in my village. So I ask did you go with your husband for testing and they say yes, I ask them to show me evidence that they did and then I tick against their name. Husbands lie so you have to call wives as well to ascertain the truth. When I cross checked the number the hospital people had and the number that I had in my book, I realized that some people lie that they went for testing. [Headman M, 2009]

While headmen cannot *legally* withhold fertilizer subsidies from those who choose not to be tested, the fact that Headman M uses the opportunity to mention testing while members of his village are arriving for their coupons is significant.[48] One the market, a bag of fertilizer costs roughly 10,000 kwacha (about $67.00 USD); with a coupon, a bag is 1500 kwacha (about $10.00 USD). Thus, everyone wants a coupon. Villagers would therefore want to make every attempt possible to stay in the headmens' good graces.

[48] This is not to suggest that it does not happen. Headmen are supposed to give the subsidies to the neediest, but it is not a law. In the observational field journals, there are complaints from villagers about not getting fertilizer.

Another headman suggested an extreme measure to Kondwani: that the government ought to withhold fertilizer subsidy coupons from men who will not get HIV-tested with their wives [Headman W, 2009].

In interviews with Village Headmen, the majority mentioned that they encouraged people in their villages to be tested for HIV, particularly the young and unmarried, such as during village meetings or funerals; a few talked about visiting the infirm and encouraging them to be tested, including asking them to return with a letter from the hospital indicating their test result [Headman A, 2009]. As one headman elaborates:

> On two occasions, I have sent villagers to Bandini health centre for HIV Testing. I had a feeling that these villagers were suffering from AIDS because of the symptoms they had. I know them and I had to use my own money for their transport. I could not stand it. They were just lying and their health deteriorating in their houses. I had to do something. [Headman I, 2009]

But Village Headmen also play another role as it regards HIV: in addition to encouraging testing, even ordering it when they believe it necessary, they also talked about using HIV Testing as a strategy for arbitrating marital disputes. While marital issues in rural Malawi are typically handled by *ankhowses,*[49] and headmen often defer to them when presented with such cases, there are instances in which they are involved directly in adjudication. In his field journals, Sekou describes a case where a married couple comes to the hospital for an HIV test upon the order of the Village Headman, who ordered a test as a means to settle a case of infidelity whereby the husband was having an affair with a woman who is HIV positive. The couple presents the counselor

[49] Ankhowses are marriage counselors, usually an aunt.

with a letter from the headman, which explains that the HIV test would help him conclude their case. The woman explained to the counselor that

> her husband has been going out with another woman. She has been hearing of the affair but she took it as just a rumour. But when she saw that her husband has started spending nights out, she made a plan to find the other woman....one night when the husband did not come, she went straight to the house of the other woman and found her husband there…When she went into the other woman's bedroom she saw two bottles of ARVs and she thought of getting them and a health passbook as her exhibits [evidence].
>
> When the issue was brought to the village headman, the village headman kept the two bottles of ARVs and the health passbook for the other woman and after preliminary submissions in the case, the village head said he cannot continue with the case until the HIV status of the two, the husband and wife, is known. She said the village headman and his aides feared that the man would have contracted the virus from his extra marital partner and passed it on to her wife and it was imperative that the HIV status of the couple be known before the case could commence.
>
> 'What can I do if my husband chooses to kill me?'...I then asked her if she and the chief considered the privacy of the other woman regardless of that she is in love with another woman's husband. She said if the other wanted her privacy and confidentiality respected she would have respected herself by not going out with other people's husbands….I disclosed their results to them that they were both HIV negative….I wrote the results in the Health passbook and wrote a letter to the village headman advising him of the results. [081006]

While the counselor was seemingly punctilious in his effort to ensure that the couple consented to the test, it is clear that an HIV test on order from a Village Headman was the only option the couple had in order for their case to be resolved in the headman's court.

Family members – including in-laws—also play a large role in encouraging, even forcing one to be tested. For example, in-laws fear for the life of their son or

daughter, without knowing whether or not a prospective spouse has a deadly virus that can infect their kin. In the field journals, Sekou describes a case of a future mother-in-law who takes her daughter's fiancé to the clinic to be tested, insisting that if he is not, she would cancel the wedding. Given the grave fear in Malawi that being HIV positive can hurt one's marriage prospects, it is reasonable to assume that one may not otherwise agree to test, nor for that matter, admit to being HIV positive. The mother-in-law thus insists on accompanying her future son-in-law for a test, and demands to remain in the testing room throughout the process:

> When this woman entered the counseling room she just said to me… 'you should test this one.'….The woman then said… 'you have to be tested otherwise the wedding will not take place'.…The woman said…meaning doctor, (me) 'this man should not leave without being tested, I was afraid if he had come here alone he would cheat [not tell the truth] on the results.' I then told the woman that HIV Testing and counseling is voluntary, a person has a right to refuse to be tested if he/she doesn't want to be tested. The woman then said…'I fear for my daughter's life. I don't know what he has been doing in Johannesburg (Joni) (Republic of South Africa).'
>
> When they came for group counseling the woman also came in. She said 'I have just come to escort this man and make sure that he is tested…' The mother insisted that she would be present when disclosing the results [as well]. I told her that it is unethical and against the code of counselor's conduct to disclose the results of a client to another person without the full consent of that particular client. I then politely asked her to leave the room while I give the results to the client. She reluctantly went out… I then disclosed his results that he was HIV negative…I then asked him if he would be comfortable for the mother in-law to know his results. He confidently said…'tell her brother.' I then invited the woman to come into the counseling room. I then disclosed the results to her of her son in-law and she just said…'it is true what you are telling me?' The man then said …'you were suspicious of my status now what do you say?' The woman did not answer, she just kept quiet. [080410]

Similarly, in another journal, Sekou describes a case of a young man accompanied by his wife to be tested. When he learned he is HIV positive, he asked the counselor *not* to record his HIV status in his health passbook. He feared that his father-in-law would banish him, as he had others who had married into the family and had suffered from sexually transmitted infections. The client explains,

> 'Brother I am married, yes but it is my father in-law who runs the affairs of our family. I was working but now I am not working. I entirely depend on the support my father in-law gives me and my fear is the moment he will discover that I am HIV positive...I will chased from his compound.'
>
> He then asked me 'brother, is it not possible that for today you write in my health profile that I don't have the virus … then I should come after three months. May be by that time I might have found a way out.' I told him that it was unethical to give false results and it would do him no good for he need to be helped so that he can access drugs to improve his immunity. He argued … 'I would rather risk not being helped other than being chased from my marriage'…. [080318]

Indeed in rural Malawi, there is a sense that *testing alone*, particularly if you are married, means that you have something to hide or conversely, something to prove. In focus group discussions, for example, villagers talked about a lack of trust and love between couples in which one partner, namely a spouse, goes for an HIV test without the other. Perhaps that is why many are escorted to be tested, such as by in-laws or an aunt who does not always trust that their family members will disclose truthfully if found to be HIV positive, particularly if the consequences threaten their partnership prospects or current relationships. And, it might also explain why, as Sekou explained to me one day, women concerned about the movements of their spouses are among the most frequent category of re-testers (those individuals who take multiple HIV tests).

Other familial concerns, however, are simpler: making sure those who are sick are aware of what is wrong with them and given proper care and treatment. In rural Malawi, as in other sub-Saharan African settings, sickness is not experienced alone and involves a family caretaker, usually a woman (Chimwaza and Watkins 2004). As Whyte, Whyte and Kyaddondo note of rural Uganda, "dealing with sickness is a social matter requiring the mobilization of others" (Whyte, Whyte, and Kyaddondo 2010). Family members typically escort relatives (such a daughter taking her mother; a father his nephew) to the clinic to be tested, the implications of which are also relevant to the next section on confidentiality.

Confidentiality

From afar confidentiality is envisaged to protect HIV positive individuals from stigma and discrimination (UNAIDS/WHO 2004). And while celebrated globally as a protective measure that will ultimately bring people forward for testing, in Malawi's villages, confidentiality is less a matter of ethics, medical privilege or even human rights, than a sign that you have something to hide (that you are HIV positive) or conversely, something you want others to know (that you are not). Moreover, confidentiality is viewed as damaging to, rather than protective of, public health. In a setting like Malawi, where the time between meeting and mating may be quite short, and where marriage, divorce and remarriage are very frequent, it would be useful to know whom not to propose for sex or for marriage. Thus, it is perceived that keeping this information hidden contributes to the spread of AIDS.

As noted in Chapter 2, in many African languages, confidentiality overlaps with other synonymous notions, such as anonymity, secrecy, privacy and discretion. In Chichewa, the word *chinsisi* covers both confidentiality and secrecy. The conflation of these two terms has stalled efforts at standardizing reporting systems for recording test results, as seen in Chapter 2; it also affects how individuals are instructed to handle their results by those who test them, as seen in Chapter 3. While some individuals tested said that counselors asked them to whom they would disclose their HIV results, or encouraged them to share their results with someone they trust, such as a relative or spouse (as per the guidelines), others explained that they were told by the counselor that it would be best not to say anything at all. One woman testing HIV negative during an antenatal visit explains what she learned from the HIV Counselor about confidentiality:

> Interviewer: You said those women [pregnant women] went outside on a queue [line]. What were they talking to each other [about] while waiting for the results?
>
> Respondent: While waiting for the results each one of us was saying, aah, I don't know what I am going to hear because the counselor said anyone who has taken the results should be going home, don't tell anyone about your results. [Respondent and Interviewer laugh]
>
> Interviewer: Did you have any concern that the counselor will reveal your results?
>
> Respondent: No.
>
> Interviewer: Okay, did this happen to anyone that the counselor revealed his/her results?
>
> Respondent: No, because he said after hearing the results don't talk to anyone outside about your results, this is for you and me only. [Client_#6, 2007]

In less extreme cases, those tested explained that the HIV Counselor encouraged them to share their test results with certain individuals, such as a spouse or close relative, but that the counselor qualified that test results are otherwise not to be shared:

> Interviewer: Do people share the experience when they go for VCT in this village?
>
> Respondent: No they don't share.
>
> Interviewer: Why you don't share?
>
> Respondent: Because the counselor said it's confidential, we should not tell anyone else, you can tell maybe your mother or your husband or your relative who you love so much.
>
> Interviewer: Mmhm.
>
> Respondent: That's how he explained. [Client_#17, 2007]

But why might HIV Counselors in rural Malawi discourage clients from sharing their HIV test results with others? Their training teaches them that disclosure is important, particularly for those testing positive, so that they will have someone to rely on to take care of them when ill and to serve as a treatment partner for accessing medication. Many counselors also see an emphasis on confidentiality as contributing to the spread of HIV, as doing more harm than good.

As seen in the previous chapter (Chapter 3), however, since counselors and clients inhabit the same social space, many counselors live with a visceral fear of being blamed when one's HIV status is found out by others. Counselors may also think they are being protective by telling people to hide, given what they hear in the newspapers about how someone who is HIV positive might be beaten by an angry spouse, or what

they learn in their training about stigma. Thus they may encourage only limited disclosure to particular individuals. This concern certainly makes sense: while many rural Malawian men and women interviewed said that they did not fear that the counselor would say anything, they were nonetheless concerned about their friends and neighbors, who will "laugh at you." As Kaler and Watkins note, now that HIV and AIDS-related information is widespread, rural Malawians see putting oneself at risk for HIV as a deliberate act, a "willful disregard of danger" (2010: 2-3). One who does so deserves being mocked for his or her foolishness.

Confidentiality is also viewed among villagers as having limited import as a prevention measure. Rather, they perceive public disclosure of HIV status as contributing to HIV prevention. One Village Headman explained that members of his village ask him to disclose the cause of death at funerals:

> Amongst the issues that are in this village is that we chiefs are accused of not disclosing the status of the deceased during funerals. This has not been brought formally but people talk about it. People here want the chiefs to say that the person has died of AIDS if the deceased suffered from any HIV/AIDS related sickness. [Headman Y, 2009]

Similarly, another headman talks about how at present, death from AIDS is spoken about only euphemistically at funerals, though the symptoms used to describe one's suffering make clear that it was AIDS-related. This same headman also asserts that if he were aware of people's HIV status, he would be well-equipped to help members of his village select suitable partners:

> I think it is important for people who are looking for ladies to marry in a particular village go to the chief and inform him that they are looking for single ladies to marry. As a chief, I can guide them to the well behaved ladies in the village. Other people just enter the village and pick a lady for a wife without even inquiring about their [sexual] history. Like that you may end up getting infected if you do not know.
>
> You know what? I feel it is important for us chiefs to be telling people at funerals the exact cause of death for a particular person. Don't hide a thing…For example at the neighboring village, there is a woman who has killed four husbands. She is HIV positive and she keeps getting married and surprisingly, it's the men who are dying and not her. Her relatives do not even bother to tell the people who are marrying her that she is HIV positive in fear of quarrelling with her. Recently she has gotten married to some man who also came in the village and married her just because she was single. He did not even bother to inquire. Some women are good. For example at Chikondwe village, there is a lady who is on ARVs, she is fat [healthy] and good looking and single but when men go to her, she tells them point blank that she is on ARVs and the final decision is theirs. [Headman G, 2009]

In communities throughout rural Malawi, the prevention methods promoted by the global AIDS community (and by the CTE in Malawi)-- abstinence, being faithful and condom use—are considered unattractive at best, impossible to do at worst. Thus, partner reduction and gathering as much local knowledge about the sexual history of a potential partner are considered much preferable strategies of HIV prevention (Reniers 2008; Watkins 2004). Popular support for at least limited disclosure, therefore, may be particularly strong in rural communities, where the village and its surrounding areas serve as the marriage and partnership market. It is thus not surprising that funerals are seen by community members as an appropriate venue to learn more about one's cause of death and make inferences about the HIV status of those the departed left behind.

Concerns about confidentiality among Malawi's villagers is not only on public health grounds, however; it is also perceived as an indication that you have something to hide (that one is HIV positive) or conversely, that you have something to prove (that one is not). In a case from the field journals, Sekou describes the insistence of one wife to know the HIV status of her husband, who was suffering from persistent fevers and diarrhea. Every time she inquired of him about his HIV status he was evasive or ambiguous, leaving her uncertain and confused. When it is explained to her by the hospital staff that it would be a violation of confidentiality to tell her the HIV test results of her husband, she threatens to leave her husband behind at the hospital in their care.[50] In response to her threat, the hospital staff succumbs and tells her that her husband has the HIV virus. The woman began her story by explaining that

> she is illiterate she doesn't understand some of the issues in the medical world. She said her husband usually told her that his results are "**Positive**" that means he is okay. She said she took this as true and continued living with him as normal. She continued saying that her husband then started suffering persistent fever and diarrhea. When the woman would ask why the fever is not subduing the man would only say I am okay, I am "**positive.**"
>
> The condition of her husband continued to deteriorate and they decided to take him to the hospital for further management. She then said that when they came at the hospital the husband has had his blood tested twice. She further said to her surprise the results of the blood tests were not being disclosed to her and she started becoming suspicious as to what her husband was suffering from.
>
> She then took courage of asking the clinician what exactly was her husband suffering from and what has been the results of his tests. The clinician told her that the patient had the right to privacy and he cannot disclose his results for they are confidential and were taken for diagnostic

[50] In Malawi hospitals, patients are attended by a "guardian," usually a relative, who provides food and care.

> purposes. The woman then told the clinician…'you are used to fooling us, I am going you will be the guardian for the patient, I don't tolerate nonsense.' She then started packing her things and as she was doing this the husband started crying, pleading with the wife not to go. The wife was not moved by this. She only said 'I want to be told the truth.'
>
> As the woman was about to leave the ward the nurse on duty called her to the consultation room…The clinician came [too] and seeing how determined the woman was to leave the husband alone in the hospital, the clinician told the woman that her husband is HIV positive and having HIV related illness. [081006]

Similarly, in another case that Sekou confronts, a couple comes to him to be re-tested. The first time they were tested, they were tested together, but the counselor had disclosed their test results to each of them separately: the wife was HIV positive, the husband HIV negative. Consequently, the wife feared that her husband was conspiring with the counselor to hide his actual test results from her. They therefore go to another health facility to be tested again:

> I then disclosed the results to the couple. And during posttest counseling the woman asked me if there is a difference in the way we do HTC at M'Dandi District Hospital and Baida Tasi clinic…She told me that when they went to Baida Tasi for testing the results were given to each of them separately. She said the counselor vacated her from the room the time he was giving the results to the husband and she thought that her husband has connived with the counsellor.
>
> The man then said brother, 'we came here just to prove a point to my wife that I did not connive with the counselor at Baida Tasi, but otherwise we already know our results. Thank you that your results and those from Baida Tasi are the same. My wife now has no case against me as it has been proved that I was innocent.'

> The woman then said 'my husband is claiming that the time he went out for business in South Africa, I was promiscuous and it's the time I got the virus. But since I got married I have never had any extramarital partner and it pains me a lot. That is why I was asking if it is possible for you to determine when the person got the virus.' I told the woman that as we discussed there are many ways of getting the virus and it would be unfair for the husband to accusing her of adultery because she is HIV positive. [081006]

The proverb "*Palibe chinsisi patziko la pansi"* (translation: "there is no secret under the sun") is common in Malawi. Anika Wilson offers two interpretations of this adage: one suggests the inevitability that the truth will ultimately be revealed and the other implies the presence of people who know information that is being hidden. For women who are suspicious of their husbands through their own observations, Wilson explains, the secret may be revealed by his frequent, unexplained or poorly explained absence. But extramarital activities is also revealed or confirmed by other people—such as observations made by neighbors, relatives and friends (Wilson 2008; also see Tawfik and Watkins 2007). An HIV test, then, may reveal the truth--the proof-- about one's sexual indiscretions. Given the low infectiousness of the HIV virus, however, many do not believe their test results when they learn they are HIV negative, especially if they are suspicious of their partners' movements or concerned about their own. Those with doubts are often re-tested, either at another clinic and/or with a frequency that does not match rationally the probability of infection.[51]

In the HIV-tested sample, for those individuals not tested for HIV for antenatal or diagnostic purposes, the primary explanations given for seeking a test were concerns

[51] Both global and local experts have been reluctant to explain that HIV is hard to transmit: thus, many who believe that they are HIV positive are not (Anglewicz and Kohler 2006).

about the HIV status of a partner or to know the cause of one's illness. An HIV test then signifies proving your husband is an 'infidel' or your wife to be a 'good one,' that your sickness does not mean you are bewitched, or in rare cases, to verify redemption or healing from G-D. One woman tested with her husband describes how members of her village were talking about her, accusing her of having extramarital partners while she was living in Lilongwe and at a distance from her husband. She aims to prove them right or wrong, and if warranted, assume moral accountability for wrong-doing:

> Interviewer: Okay, at first what made you go for VCT?
>
> Respondent: At first what happened is that, as I have said, there was some disagreements between me and him [my husband], so with these disagreements then we were separated…Some people were talking a lot.
>
> Interviewer: About what?
>
> Respondent: 'Eeh your wife where she was [living] she had bad sexual behaviors, eeh you have made a mistake.'
>
> Interviewer: What mistake?
>
> Respondent: They were saying that my husband made a mistake by following me [to] where I was [my home village in Lilongwe]….So some people here were saying that maybe I had bad sexual behaviors in Lilongwe, mmhm. [They said] So your wife will make you die, so when I saw this, I saw that it's not a wise thing for me to kill my friend [husband] if I did a bad thing it's better for me to die and leave my friend [husband] to take care of [the] children. That's what encouraged me to go to the clinic. [Client_#29, 2007]

But it is not just cases of infidelity that are the subject of rumors in Malawi's villages; they also abound in the case of unexplained illness and death (see Farmer 1992 for Haiti). Whenever someone dies, the question is raised: who is to blame (Ashforth and Watkins 2009)? *Someone* must have caused the death. Since evidence indeed

counts, it is fitting that an HIV test might trump stories of witchcraft, as illustrated in the words of one woman who thus views favorably the government's mandate of routine antenatal testing: *"*...people die and at the end of the day we think that it is witchcraft. That is why the doctors put this time for people to go for [HIV] testing so that we should not put blame on witchcraft in the villages" [Mixed_fgd_#3, 2009]. Another woman explained that she was tested for HIV to end rumors about illness in her family:

> Respondent: What made us to go for VCT was that, when my husband was getting sick frequently, then my child also got sick, people were talking a lot: the child is sick and the father is also sick, is that not a disease he transmitted to the child? So for me to end the rumors that's when I told my husband about VCT so that we should know our status and know how to care for our life. [Client_#3, 2007]

Counseling

HIV counseling has several announced goals: for individuals to learn more about their risk for HIV infection; to help them make decisions that are better orientated towards behavior change to avoid HIV infection or giving it to others; and, if HIV positive, to learn about how to live well ("live positively") with the virus, such as proper nutrition and, if eligible, access antiretroviral treatment. Villagers, however, respond variously to the HIV counseling messages they receive. While many seemed satisfied enough just to be seen by a health provider, others spoke of the advice provided to them as improbable and undesirable. And while the global AIDS community perceives ARVs as a good thing, again—as with HIV Testing—villagers are ambivalent.

For the majority of those tested in the interview sample, counseling was quick, generic and informal. Much of what is said by the counselors is redundant. Respondents

mentioned being told to follow the ABCs, the behavioral prescriptions that have dominated AIDS advocacy and social marketing campaigns for nearly two decades: abstinence, being faithful and condom use. They were also told to take good care of themselves by avoiding "bad behaviors" and to have only one partner—again, messages that have been broadcast for a long time. Those who tested HIV positive could easily repeat to the interviewers the "positive living" messages promoted internationally, although with a local flavor: eating nutritious foods, not losing hope, praying hard, joining support groups and agreeing "not to kill themselves."

Although the advice given by the counselors largely follows the international (and national) guidelines, the counseling itself deviates from these guidelines. And although training manuals dictate that HIV counseling is to be a dialogue, in practice it appears largely didactic:

> Interviewer: Were you free to ask questions to [of] the counselor?
>
> Respondent: They told us that anyone with a question should ask, so [but] we felt that even if we ask a question it is not helpful because we were obeying what he was telling us as a doctor [counselor] and we had to make use of what he was telling us.
>
> Interviewer: Did he ask you any questions?
>
> Respondent: Yes, he was asking [us questions].
>
> Interviewer: What question[s] did he ask?
>
> Respondent: 'Are you hearing me?' We were answering, yes [laugh]. [Client_#15, 2007]

In addition, the process draws from exercises in verification that are used in schools throughout the region and is thus familiar to counselors and clients alike. The clients are

asked to repeat back what the counselor has said, as if the clients were schoolchildren and the counselors their teachers (Carter 2008):

> Interviewer: Okay, were you free [able] to ask questions?
>
> Respondent: Yes, we were free [to ask questions] when we were to be given the results not when we were going three at once [in groups].
>
> Interviewer: Ooho, what question did you ask?
>
> Respondent: He [the counselor] asked us, if a person is found with this virus is it good for her not to bear children again or be married, so he asked us that question so that we should answer, then I answered. I said it's good for a person not to bear [children] again because during birth giving you lose a lot of blood and the sickness continues.
>
> Interviewer: Mmhm. Were you free [allowed] to ask the counselor a question?
>
> Respondent: No, I was not free. [Client_#31, 2007]

Despite the didactic and often patronizing nature of the counseling, the majority of the clients interviewed said they were satisfied with their own HIV counseling experience, especially if it met their primary objective in seeking health services-- to be helped with medicine. The eagerness to access treatment is nicely captured in the words of a man who tested HIV positive: "If they [ARVs] are being sold…I will sell my goats to have them" [Client_#22, 2007].[52] The infrequent complaints about the counseling were not about the substance of the counseling, but rather about rude health personnel or having to wait for long periods of time to be seen, experiences that are far from unique to HIV Testing in many sub-Saharan African health facilities (for examples see Bassett,

[52] With the support of Western donors, ART became free in Malawi in 2004.

Bijlmakers, and Sanders 1997; Jewkes, Abrahams, and Mvo 1998). As one woman explained of her experience being tested:

> Respondent: One day I went for VCT. The doctor came and took blood on my finger. After some hours he was passing by and I asked him about my results. He started shouting at me. 'What do you know about blood testing? Do you want to rule us here? You are not at your home. This is my time. You are in the hospital. Follow our rules here.' [Client_#7, 2007]

There is some difference between what respondents said about counseling in the interviews, what they said in focus groups, and to a greater extent what they said in the observational field journals. In these other sources of data, rural Malawians appear less satisfied with the public health counseling advice they receive in the counseling room, which strikes them as not only unsuited to their lives but also undesirable. As Watkins shows, throughout Malawi's villages, individuals develop alternative prevention strategies in the context of their own social networks, particularly when the generic prescriptions for avoiding HIV risk (namely abstinence, fidelity and condoms) rob them of what they believe to be a core element of a good life: a variety of sexual partners and "plain" sex, i.e. sex without a condom, that is, sex "flesh to flesh" (Watkins 2004). Condoms are largely rejected in this setting, with the exception of commercial sex. They are viewed with suspicion as a form of population control (Kaler 2004), as undermining trust and love in marriage (Chimbiri 2007), and/or as signifying a risky, less serious partner (Tavory and Swidler 2009). In a focus group discussion, one man shares his own experience (not) being tested for HIV, a situation from which he jettisons upon being told he would have to give up what he enjoys:

> Man #5: There was a time I sneaked to go to the VCT centre without my wife's knowledge. I run [ran] away from HIV testing centre because the advice they gave me at the beginning was not good. They told me that if they find me positive I will have to stop drinking beer, smoking and all sorts of things that I really like doing. So I run away and did not get tested. [All laugh] and [Man#5 continues to say] I just gave them an excuse saying I did not inform my wife that I was coming here so I needed to go back. [Men_fgd_#1, 2009]

In other cases, counseling advice seems simply absurd to its recipients, as illustrated in one journal. Sekou tells a female client whose husband is HIV positive and demands to have sex with her without a condom that his actions are a case of "gender-based violence" or "date rape," the language of human rights learned in the HIV Counselor training. The woman laughs at the mere suggestion: 'who do you think can agree that a man can rape his own wife? My relatives and everyone would take it as a joke,' she tells him [080416].

Although the international community sees testing as a "gateway" to care and treatment (UNAIDS 2002), with the HIV Counselors as gatekeepers (Fox and Goemaere 2006; Whyte et al. 2004), the counselors actually say little about treatment. The HIV Counselor training manual says it is their job only to "make referrals" for ART, not to discuss how to take the drugs or how to manage one's life on them (Ministry of Health [Malawi] 2007b). Of those clients interviewed, 47% were HIV positive; however, the majority of them (79%) were *not* on ART. In some cases, respondents said the counselor did not mention ART at all; in others cases, they were told only to return to the hospital if they get sick. Rural Malawians are well aware that ARVs are free and available and they know people in their villages taking it. They are also familiar with the drugs'

impacts on the body, namely that it makes you sick (e.g., dizzy, diarrhea) in the beginning and ultimately "fat" [healthy]. Many, in fact, have expectations about starting treatment when they go for testing, especially if they are sick and suspect their illness is AIDS, though some expressed fears of the drug's side effects.[53]

But even when the HIV Counselor does give medical advice to those who test positive, that advice is perceived largely as discouraging, inappropriate to their lives, and, perhaps most importantly, antithetical to their individual aspirations. In the journal entry below, Sekou describes a case he handled of a young woman who is HIV positive. She is engaged to marry and fearful that disclosure of her test results to her boyfriend (fiancé) would threaten their marriage and her chance of having children, as it had ruptured her previous relationships. Despite the extensive counseling Sekou provides her, the young woman remains dissatisfied and saddened. Their exchange in the counseling room illustrates the clash between the public health messages of counseling and the socially normative desires of young rural Malawians. She explains to the counselor:

> I am in love with a certain man who wants to marry me. Every time when we want to have sex I insist he uses a condom but he refuses. He says he had been tested before and he is HIV negative. I also just told him I had had an HIV test too. We have had sex for three times without a condom. But recently I wanted to tell him my status but he said 'do not bother telling me your status. I went for an HIV test two weeks ago and I am HIV negative. This means that you too are HIV negative'….

[53] Starting ART requires that an individual first meet ART eligibility. Eligibility is determined either by a CD4 count, or if the hospital lacks a CD4 count machine, by clinical staging standards developed by the WHO, described in Chapter 1. The individual must then undergo ART counseling, a two-week process involving several group counseling sessions with an individual they designate as their "treatment partner." ART counseling is a separate training course for health workers. I discuss this process in the concluding chapter (Chapter 5).

She then tells the counselor

> that disclosure had done her more harm than good in that she lost three marriage opportunities. She narrated that every time a man come to her for marriage proposal and she becomes open to disclose her status to him, the moment the man learns about her status, he ends the affair. She said this has happened to her three times…She then decided not to tell him and continue in their relationship. She said the man loves her and has asked her for marriage. But her main fear is that when she will disclose her status it might be the end of her marriage…

The counselor then explains to her that there are families in which one spouse is HIV positive and the other HIV negative. She responds to him:

> The families that you are talking about have been in marriage for several years. And have children therefore they have nothing to lose. Just imagine young as I am, to start a marriage life with condoms and to live without a child, it is much painful, that is killing someone, it is not fair. The more you disclose the more miserable you become as no one can have the courage to marry you.
>
> She said she feels the counseling we give to the people with HIV positive results is somehow discouraging. She told me first imagine you tell us…from now on when you want to have sex you should always use a condom and moreover you should not be pregnant as this would cause some delivery complications.
>
> I then told her that what we tell them are recommendations. We do not force them to abide by what we recommend. We just give information on the advantages and disadvantages of certain things that can happen to an individual. The choice remains with the clients to choose which things he/she thinks are more useful to him. She said no, you people talk to us a verdict saying since you have been found with the HIV virus this is your way of life, condoms always and no child for the rest of your life that is how you express it to us. She continued saying that was what I was told the time they found that I was HIV positive and I have stayed without a hope of getting married and having a baby. [080905]

This exchange also illustrates the different perceptions providers and clients have of "counseling": what the young woman sees as directives without options, the counselor sees as recommendations.

After that young woman leaves the counseling room, Sekou takes the opportunity to talk to a married couple and then a Pastor, all of whom are HIV positive, to inquire about their views on condoms and child bearing. He is surprised to hear them say that they actively disobey the advice given to them by health workers. As the husband explains to him:

> 'You health workers you give final verdict you tell us no children, no plain sex. We should just stay for the rest of our lives. My wife and I agreed to ignore the use of condoms. Here we are up to now we are just very healthy.'
>
> I didn't comment because he too seemed to be against the idea behind no child, no plain sex. I talked to one of the Pastors who is HIV positive but has a baby. He told me that he decided to have a baby to prove to the people that being HIV positive is not the end of life, life goes on, he said to me. [080905]

Rural Malawians realize that it is possible to live longer, healthier lives with HIV now that ART is available, and they have heard the routine counseling messages that emphasize hope and optimism. As one woman who tested HIV positive recalls of what the counselor told her, "HIV is not the end of your life, but the beginning of a new one" [Client_#9, 2007]. But living a normal life means fulfilling individual aspirations and social expectations-- which in Malawi, as in most African societies, includes marriage and having children (Caldwell, Caldwell, and Quiggin 1989; Fortes 1978; Smith and Mbakwem 2010). And, as Yeatman explains, while being HIV positive is largely a private affliction, at least until someone is suffering from the visible effects of AIDS disease, being childless is almost invariably public and stigmatizing (2009: 270). It is

thus not surprising to find that HIV positive individuals – and couples – may reject the advice given to them by counselors.[54]

Indeed throughout rural Malawi, there is deep ambivalence about what the global community (as well as the CTE and HIV Counselors) sees as the miracle of ART. Rural Malawians see neighbors who are on ARVs and know that being HIV positive is no longer a death sentence. But they also experience it as a sort of "*social* death sentence" (Smith and Mbakwem 2010: 347), particularly the young and unmarried who are often advised against pursuing normative life course desires if they are HIV positive.

For the uninfected, however, ARVs pose a qualitatively different concern: they make it more difficult to know who has AIDS and they keep those with HIV living longer. Consequently, rural Malawians fear a higher likelihood of unknowingly being exposed to someone who is infected. In the journal entry below, Sekou captures a conversation among a group of men and women debating ARVs during a pre-test group counseling session. The session begins with the counselor asking the group how one can prevent infection from HIV. As with most pre-test counseling sessions captured in the journals, it ignites a populist critique of the "book" answer to prevention:

> When we came to the section on "positive living" during the pretest counseling, the issue of ARVs raised some debate on whether ARVs should be given to those who have the virus or not. It all started when a certain man said… 'you people should know that AIDS will not end because of the drugs you give to those who have the virus you make them become healthy as a result they start experiencing sexual desires.' He continued saying… 'imagine a person who was used to having sex with women and now his sexual desire is back, what do you think he

[54] In their study from Northern Tanzania, Paoli, Manongi, and Klepp (2002) find that HIV positive mothers go against counseling advice by breastfeeding their babies for fear of being perceived by others as HIV infected if they don't.

> will do? About these condoms we just say it in this room [we say we will use them] but when we are with our partners some do not use them.'
>
> The group was sent into another laughter when he said… 'you should not give drugs to those who have the virus since they regain their energy and sexual desire. Government should do something otherwise AIDS will not end.' Then another woman said…'the government is not to blame but people do not appreciate what the government is doing, you see men who have regained their strength proposing women when they know they are infected. Women too who have regained their strength seduce men.'
>
> The man insisted that it is better not to give the ARVs to those who have the virus since they start misbehaving after they have recovered their form and he said… 'you should tell the government to look at this issue critically.' Then the woman who had not talked before said … 'if you have a problem is your own concern, your friends are being assisted by the same drugs.' [090401]

In a more specific exchange from the journals, Sekou describes a woman who comes to the clinic for ARV "top-up," a term used colloquially to refer to a prescription refill.[55] On this woman's previous trips to the hospital, the hospital guard (watchman) had thought she was coming to collect medication for someone else. Upon realizing that the ARVs were in fact for her, the guard and his friend discuss the dangers that ARVs pose to men who are seduced by attractive women:

> Soon after we [the counselor] had separated with the lady, the watchman who was at the gate listening to us said…'people with HIV now look healthy and better, and men who love women will be at risk for they cannot tell from the looks that these women has the virus.' I did not comment on what he said. Instead another man who heard what the watchman said, answered him saying…'you were admiring her figure, all that glitters is not gold.' The gate man said…'it doesn't matter if you die but you have slept with a nice [attractive] lady.' [080410]

[55] Locally, "top-up" refers to the purchase of pre-paid "minutes" or "airtime" for the use of cell phones.

The guard's remarks suggest an indifference to death if it means having sex with a good looking woman.[56] More importantly, however, they reveal a concern among many that drugs designed to save one person will ultimately kill others. While Kondwani and I sat outside the dispensary of the M'Dindi District Hospital, a gentleman in his early-30s, quite tall and muscular, turned to him and remarked: 'We all look normal out there when we are in the public, but when we get here [to the hospital], that is when we get to see it is difficult to tell who is on ARVs and who is not.'

DISCUSSION

This chapter examined the ways in which HIV Testing's "3Cs" (consent, confidentiality, and counseling) are received and experienced by their intended beneficiaries. Despite official rhetoric on the import of the "3Cs" within the global AIDS community, and among its champions in the CTE in Malawi, they are not fully embraced by rural Malawian men and women, the targets of their efforts. Rather, consent often generates local contests over authority, such as power struggles among and between HIV Counselors and clients, husband and wives, Village Headmen and villagers. Confidentiality may cultivate distrust and secrecy, particularly when a person tests for HIV *alone*. And counseling messages, particularly for those who test HIV positive, leave people largely unsatisfied and discouraged when the advice they receive robs them of the elements of a good life (such as having "plain sex") and pursuing normative desires and social aspirations (such as having children). In short, for rural

[56] Also see Kaler 2003a on the reconfiguration of masculinity in an era of AIDS.

Malawian men and women, the "3Cs" have little inherent value, and are perceived largely as doing more harm than good in their communities.

This is not to suggest, however, that rural Malawian men and women support doing away with testing for HIV.[57] People do say, at least to an interviewer, that testing is a good thing, and some even go as far as saying it should be mandated (and the results disclosed to all as an approach to prevention). But others vigorously object to compulsory testing and take matters into their own hands, such as avoiding antenatal testing in clinics where it is perceived as compulsory (Angotti, Dionne, and Gaydosh 2010). Nor do people complain about the "3Cs." To the contrary, they want to be sure that the HIV Counselor will adhere to the principle of confidentiality, for example. Rural Malawians can, and do, disclose their results to others, but they want to disclose it themselves, not have it disclosed by the counselor.

In the next and final chapter (Chapter 5), I bring together the three perspectives considered in this dissertation – the Counseling and Testing Establishment, HIV Counselors and rural Malawian men and women – and provide a detailed discussion of this study's major substantive findings.

[57] In a study of door-to-door rapid blood testing for HIV in the same villages considered in this dissertation, 92% of rural Malawians accepted the offer of an HIV test and 98% of them learned their test result (Angotti et al., 2009).

Chapter 5
Discussion and Conclusion

This project set out to understand what happens to Western ideas when they are incorporated in non-Western settings. The empirical object of study was the "3Cs," the cluster of Western norms and ideals upon which global HIV Testing policy rests: (1) that it includes *counseling*, (2) that testing be conducted with informed *consent*, and (3) that the test results be *confidential*. My point of departure was that the institutionalization of these ideas has already taken place in the global polity (UNAIDS 1996; UNAIDS/WHO 2004) and has been adopted, almost verbatim, in the policy documents and training manuals produced by national governments (Ministry of Health [Malawi] 2004; Office of the President and the Cabinet and National AIDS Commission 2003).

I utilized a 'multi-level' approach – that is, how different program participants at different levels of social organization—interpret, and put into practice, the same ideas (van der Geest, Kinsman, and Hardon 2010). Then, through several methods of field research focusing on the various actors who inform the HIV Counseling and Testing encounter in Malawi (the Counseling and Testing Establishment, HIV Counselors and rural Malawian men and women), I investigated how the "3Cs" took on new meanings and practices as they moved from international headquarters in Geneva, through Malawi's national bureaucracies, to village clinics and homes spanning its rural landscape. In this final chapter, I attempt to bring this story together. I begin by highlighting this study's major lessons and consider what this inquiry teaches us about

larger social phenomena. Next, I consider important methodological implications of this study. I conclude with projections for what we might expect in the years to come.

This study's punch line is simple and not surprising: there is a wide gap between policy and practice, between what is written on paper and what unfolds on the ground. Across the levels of social organization considered in this study, people have different interests in – and thus, different ideas about -- the "3Cs" (van der Geest, Speckmann, and Streefland 1990: 1033). In sum, for the Counseling and Testing Establishment (Chapter 2), its *proponents*, the "3Cs" are Western, human rights imports that are worth defending formally, but not necessarily worth prioritizing in practice. For its *implementers* (Chapter 3), HIV Counselors, knowledge of the "3Cs" as Western biomedical jargon helps distinguish them from ordinary folk, but leaves them entangled in situations where the ethics of testing conflict with moral concerns they have for those whom they were trained to help; thus they adapt them in practice. And for its *beneficiaries* (Chapter 4), rural Malawian men and women, the "3Cs" have little inherent value, and are perceived largely as doing more harm than good in their communities. Thus, the net contribution of this study is that HIV Testing's "3Cs" have no "fixed meaning" as a normative testing regime, but rather acquire (differential) meaning (and import) during the course of their implementation (van der Geest, Speckmann, and Streefland 1990: 1033).[58]

[58] They also very likely acquire differential meaning in the course of their transmission from international headquarters to national documents. This empirical question, however, is beyond the scope of this dissertation.

As this dissertation's chapters have shown, the implementation of HIV Counseling and Testing in sub-Saharan Africa has "unrecognized, unintended and emergent consequences" (Portes 2000: 1) that extend beyond the realm of AIDS. The unintended consequences of actors seeing HIV Testing's core guidelines ("3Cs") differently are both the result of clear differences between and among actors in their perspectives-- given their concerns, interests, training and social positioning -- and also arise structurally from the attempt to rationally reconstruct society in an underdeveloped country (Coleman 1993). I extend this argument about externalities below with attention to three considerations.

The first explanation for the differential incorporation of Western HIV Testing norms in SSA has to do with the *application* and *translation* of foreign imports. As Pritchett and Woolcock argue, one of the ironies with planned interventions is that development *solutions* often become problems themselves. The authors identify the problem as one of "seeking to quickly reach service delivery performance goals in developing countries by simply mimicking (and/or adopting through colonial inheritance) the organizational forms of a particular [developed country]" (2004: 193). While in this case the institutional practice adopted ("3Cs") arose in the global (Western) community, the theoretical argument still applies: the "3Cs," seeped in human rights and ethics, did not emerge in SSA first, but were rather adopted more or less intact from elsewhere (DeCock, Mbori-Ngacha, and Marum 2002) and consequently pose problems for practice (also see Portes 2006; Scott 1998). Thus, while the "3Cs" in matters of HIV Testing may be the global (and national) "solution" to balancing public

health goals with adherence to international conceptions of human rights, the outcomes may be quite different from that envisaged officially. These differences arise from the extent to which the actual implementation of the "3Cs" (that is, the act of applying them from paper to practice) is an inherently "discretionary" process, that is, "their delivery requires decisions by providers to be made on the basis of information that is important but inherently imperfectly specified and incomplete, thereby rendering them unable to be mechanized" (Pritchett and Woolcock 2004: 194). As seen throughout Chapter 2, as well as the opening field note in Chapter 1, HIV Counselor Trainers must teach testing guidelines to aspiring counselors. But the process is often riddled with contradictions and confusion because the guidelines (and concepts) themselves are vague, and thus, difficult to explain. For example, as noted in interviews with the CTE and illustrated in observations of HIV Counselor trainings, confidentiality is understood in a lot of ways, with consequences that are both social (communicating a new meaning about the disease by making it synonymous with "secrecy") and structural (impairing efforts at standardizing test results, necessary for the "successful" implementation of confidentiality in a bureaucratic organization). Similarly, there is no clear consensus on the process of seeking informed consent for patients whom are the targets of routine, opt-out testing strategies (necessary for the "successful" implementation of consent).

Thus, the "3Cs" become quite problematic for their implementers. HIV Counselors, now charged with the task of translation after they are certified as counselors, may not be entirely clear on what it is that they are explaining. For example, if pregnant women should be tested for their own good and for the health of their unborn

babies, then how much (and how strictly) should consent be enforced in practice? Such confusion may lead to unforeseen consequences for public health, such as women being denied antenatal care if they do not consent to an HIV test (Angotti, Dionne, and Gaydosh 2010). In short, the implementation of the "3Cs" as a "planned"-- albeit discretionary--public health intervention, seems to be imperfect at best, counterproductive at worst.

The second explanation for the differential incorporation of the "3Cs" has to do with the *social status* and *reputation* of role occupants (Portes 2006). Social status is important because it offers mobility and confers greater access to power and resources (Roth and Wittich 1978). AIDS, particularly the immense global interest in it, has transformed the landscape of opportunity in poor, high HIV prevalence settings throughout sub-Saharan Africa, opening up new jobs in the formal labor market, new specialties, and new sources of income (see Swidler 2006). As discussed in Chapter 1, this has included *inter alia* unprecedented multilateral and bilateral funding support, all devoted to one disease (England 2007; Shiffman 2006; Shiffman 2008).

For the Counseling and Testing Establishment (CTE), their livelihoods depend on foreign aid and interest in HIV Testing, and especially on the huge expansion of antiretroviral treatment, for which testing for HIV is a pre-requisite. Increasing the number of those tested, and placed on ART if they are eligible, is an easily interpretable indicator of program success. Since numbers tested and treated are easier to measure than adherence to human rights principles, in the funding world, it is no surprise that these are used when funders want to know that what they are funding is having its stated

effects. But on the other hand, the more AIDS is considered an emergency, a problem needing huge sums of money to address effectively, the more implementers stand to gain in terms of opportunities to make a living. Thus, as seen in Chapter 2, it is not surprising that the CTE see any problems affecting the implementation of the "3Cs" as remedied by those solutions that their professions are designed to handle: if HIV Counselor performance is weak, for example, there is a need for more training, clearer guidelines, and better policies and procedures. And, as with most problems for implementation, blame is assigned to others, in this case the implementers, HIV Counselors, a group that the CTE trains, certifies and supervises.

For HIV Counselors, the rewards are less material, though not less significant: in addition to new occupational opportunities, they gain a modern, educated identity (Johnson-Hanks 2002). This identity is based on the expert knowledge that they learn and then transmit, such as the difference between HIV and AIDS and the definition and importance of the "window period" (the amount of time it takes for the body to develop antibodies to HIV).

The extent to which opportunities and identities are transformed by the flood of funding for AIDS varies in Malawi. Those counselors who are also trained nurses, for example, may already feel well-positioned with the permanency of a public sector job; those individuals without advanced professional training who are working full-time as HIV Counselors for NGOs, on the other hand, may hold the glimmer of hope of advancing to more secure work with greater ties to Western donor projects, thus escaping the trajectories of most in their villages who are reliant largely on subsistence

farming and trading for survival (Swidler and Watkins 2009). HIV Counselors acquire through their training a new skill set and, especially important for their sense of identity, a command over the rhetoric of the Western biomedical repertoire. Both the skills and the rhetoric distinguish them from the ordinary folk whom they must educate and "enlighten" about HIV. The skill set that this new identity affords may indeed be fungible: for example, as seen in Chapter 1 and Chapter 2, some of the members of the CTE working now as HIV Trainers were once, themselves, nurses working as Family Planning Counselors or HIV Counselors. They were able to leave the public sector and transfer their skills in HIV Counseling and Testing—or counseling more broadly-- to other available, emerging positions in the AIDS industry.

But in the villages in which HIV Counselors live and work, while their status as HIV Counselors distinguishes them from ordinary folk, it also makes them the targets of local surveillance. Their actions are monitored carefully for practicing the "good" behavior they preach, for hypocrisy (promiscuity, drinking) and, especially relevant for the monitors, whether they can be trusted to observe confidentiality. Their actions are interpreted as indicators of their character, as seen in Chapter 4. HIV Counselors are also well aware of this. As Aaron, an HIV Counselor in his mid-20s remarked to me one day as we passed a notorious bar in a trading center near his village, 'They [people in my village] can't see me going [there]. That place is full of bitches [sex workers].'

For villagers, those for whom HIV Testing's "3Cs" are meant to help, the "3Cs" have different valences. To test alone (as voluntary and confidential testing implies and encourages), signals to others that you have something to hide, for example that you

have "misbehaved."[59] Or it signifies that that you have something to prove, first to yourself, and ultimately to your community – that, for example, your partner is an infidel who is trying to kill you with AIDS or that the sickness in your family is not a form of bewitchment. Ironically, for all that stigma is purported in the global AIDS community as a reason people are afraid to test, and thus the slavish commitment to the notions of consent, confidentiality and counseling since the test's inception, in rural Malawi, people often suffer the stigma of *not testing*. It is increasingly becoming seen as morally incumbent on individuals to test (and to disclose their results), particularly if their test outcome can affect another. For example, as seen in Chapter 4, pregnant women are seen as willfully disregarding the health of their unborn child if they do not wish to be tested during their antenatal visits. She also becomes the subject of community ridicule as having something to hide-- that is, that she is already HIV positive. As also seen in Chapter 4, men too are censured for evading testing. Village Headmen thus mentioned that they utilize their power for the testing cause by developing their own local strategies (e.g., a tracking system) for encouraging men to accompany their wives to antenatal clinics to be tested.

A third, and final, explanation for the differential incorporation of the "3Cs" has to do with *plausibility structures*, a term coined by the eminent sociologist of religion Peter Berger (Berger 1967). Plausibility structures refer to the network of individuals who share and help reinforce one's meaning system, meanings that are so ingrained, they often go unquestioned. As Regnerus notes about plausibility structures: "norms are

[59] It is important to note, however, that couples counseling and testing is promoted in Malawi by the CTE (Ministry of Health [Malawi], 2006b), as elsewhere in the region where the HIV epidemic is generalized.

kept alive by networks of people, organizations, and communities who tell each other that some ideas, actions and arrangements are good and optimal, and some are bad and ought to be resisted" (2007: 159).

In rural Malawi, the introduction of the "3Cs"—the imposition of Western worldviews through a public health intervention intended for community and individual health benefit-- has challenged the (pre)existing social order. This is the heart of the dilemma that HIV Counselors face in the course of doing their jobs, and the source of conflict they confront with those they are meant to help. In short, the values and norms operating in rural Malawi are quite distinct from those inherent to the Western-oriented "3Cs." On one hand, counselors are required to uphold the ethical requirements of their jobs, ones introduced to them for the first time in their training and that are written on the pages of the testing manuals they own. But the extent to which the "3Cs" are reinforced *outside* their offices is less well known. In practice, they daily confront individuals with whom they inhabit the same socio-cultural space: in theory, the plausibility structures more closely aligned with villagers may be stronger. Malawi's HIV Counselors share with their clients a respect for the institution of the family and the family's legitimate obligations to, and claims over, their members. Thus, as this study has shown, they may be loath to enforce voluntary testing in its strictest sense when one family member, such as a father, insists that his grown children be tested. Or they may be loath to enforce confidentiality when a wife, who will shoulder the responsibility of care, insists on knowing the HIV status of her sick husband. Clients inform the counseling and testing encounter as well and often seek out the counselors they know for

additional help. It is often in these situations that HIV counseling is *most* effective and both parties jointly served: as seen in Chapters 3, clients are prayed with, are accommodated in the homes of a counselor, and/or delivered food if they are HIV positive and needing to eat to take their medication.

Conversely, as seen in Chapter 4, conflict between counselors and clients emerges when the "3Cs" prevail over pre-existing social norms. For example, the messages HIV Counselors "advise" about prevention from their training – such as condom use and avoiding child-bearing – are at odds with the deeply ingrained values and import afforded to marriage and fertility in this setting. Condoms are seen as unnatural in marriage, an institution "invented by G-D" (Chimbiri 2007: 1111); child-bearing is a normative "life project" in Africa societies, one with profound social significance (Smith and Mbakwem 2010) and the stigma of being childless is indeed a public one (Yeatman 2009). For HIV Counselors, however, while they may be sympathetic, the salience of the public health rationale for avoiding HIV infection may dominate over the concerns of their fellow village members about not wanting to wear a condom or not being able to bear a child.

The space where counselors and clients interact is a world – a network of individuals—whose interactions and shared meanings are largely beyond the imagination of most members of the CTE, many of whose careers have removed them from the quotidian realities and shared values which permeate village life. For example, while the CTE expresses the problems with counseling as HIV Counselors not taking a client's individual concerns into account, it is the *content,* the behavioral prescriptions,

of counseling messages that clients largely reject. Indeed as others have observed, elites revert largely to stylized versions of community practices circulating in the global AIDS community to talk about AIDS, such as "sugar-daddies"[60] and "vulnerable women" (Tawfik and Watkins 2007) and cultural practices such as *chokolo* and *fisi*[61] (Wilson 2008). Elites speak largely of cultural practices that *harm*, rather than help. This makes sense as it may mean that more money will be devoted to trainings, developing educational manuals, and other related efforts that aim to change these ways. As such, it may be hard (arguably, unwise) for the CTE to envision where counselor adaptations of the guidelines may, in fact, be helpful and desirable to rural Malawian men and women. For example, counselors may be taught in their training to encourage clients to pray if they are HIV positive (and as advised in their training manuals), but they are certainly not taught to pray *with them*, as observed in Chapter 3. This is not to suggest that the CTE would necessarily discourage it. However, it is nonetheless at odds with what the CTE do promote as a counseling goal, which is *self-reliance*, a Western idea predicated on notions of individualism and largely antithetical locally to what it means to be helped (also see Stone 1986).

METHODOLOGICAL CONSIDERATIONS

This dissertation considered perspectives from various social actors, utilized several methods of field research, and consequently, emerged with very different perspectives of HIV Testing's guidelines ("3Cs"). Having just considered a set of

[60] "Sugar daddies" are older men who pay younger women for sex.
[61] *Chokolo* is wife inheritance; *Fisi* is when another man assists to impregnate one's wife.

substantive explanations for these differences, I now offer a set of methodological considerations for the observed discrepancies.

It is no news to social scientists that participants are mindful of, and thus actively shape, what they say to interviewers as well as what they say to one another in informal social interactions. "Presentation of self" (Goffman 1959) is a sociological axiom. Social scientists also recognize that the validity and reliability of reporting is thoroughly affected by the attitudes of respondents towards those who interview them, which may vary cross-culturally (Weinreb 2006: 1014). Weinreb (2006), for example, tests interviewer effects on a collection of survey data in a rural sub-Saharan African setting. He finds that "insider" interviewers – that is, those *not* foreign to the research setting-- do a better job at collecting reliable data than "stranger" interviewers. I cannot replicate Weinreb's study with the data from this study. I can, however, offer a different perspective on what positionality (i.e., being a "stranger"[62] *ethnographer* to the research setting) meant for the data collected.

There were compelling methodological reasons to utilize different methods of inquiry (see Plummer et al. 2004). With this in mind, I integrated strategically *four* different forms of qualitative data: participant observation, interviews, focus group discussions and observational field journals. What would we have learned had this study utilized only *one* qualitative method of inquiry? In what follows, I give preliminary consideration to this counterfactual.

[62] I distinguish my use of the word "stranger" from Weinreb's use of "stranger," which he defines as having "no prior social relationship with respondents" (2006:1014). Indeed, the process of fieldwork is often an on-going endeavor to develop social relationships with informants. I was a "stranger" to the extent that I was "foreign" (i.e., Western; non-Malawian) to the research setting.

Participant Observation

My work as a participant observer frames this dissertation, so I begin with a reflection on positionality. Not surprisingly, each group of actors had its own strategy for dealing with me, and even with my field assistants, who they knew were working for a *wzungu*. Across all groups, I was seen largely as either a donor or an "expert" until explained otherwise, which regardless, afforded me access and entry that helped me conduct fieldwork with greater ease. The local perceptions of me as either a donor or an "expert," however, is not surprising: the overwhelming majority of expatriates in Malawi is working for Western development organizations, or involved in studies by overseas universities or other global research institutions. Nonetheless, it troubled me. On a handful of occasions, for example, health workers prioritized my visit over tending to the hundreds of patients in front of me that had been waiting hours to be seen. While their intentions, at least in part, might have been acts of graciousness to accommodate a "guest," informants also perceived to have something to gain. Indeed, every health facility (and NGO office) I visited asked me to sign the guest book, indicating my name, date of visit, country of origin and organizational affiliation. And many took the opportunity to share with me those things they thought I could change, or be the conduit for changing, with the expectation that I would share their concerns with important "powers that be."

Even as a silent (participant) observer – such as of HIV Testing sessions or my observations of HIV Counselor trainings-- my mere presence (and Western embodiment) "spoke." For example, while it is typical to have external observers in the

HIV counseling room in Malawi (HIV Counselor trainees, for example, must complete two weeks of clinical observation of HIV Testing sessions; HTC supervision of HIV Counselors is part of routine practice), the counselor was likely "performing" as the "good counselor" in my presence. During my observations, an extended explanation of the testing process was provided to clients and a prolonged amount of time was spent counseling each client individually. While this also might very well reflect individual attributes of the HIV Counselor, it is nonetheless relatively atypical of the experiences shared by those individuals tested for HIV in the client sample, as seen in Chapter 4.[63] Nonetheless, my ethnographic observations captured HIV Testing *in situ*: it showed the various circumstances that bring clients in for testing; how client cases get differentially handled; those cases that confuse, trouble or amuse counselors; and how clients variously respond, both in their interactions with HIV Counselors and to their own HIV diagnosis.

There was likely less "performance" in the HIV Counselor trainings as Trainers had a much larger (and arguably, more important) audience than me in front of them: 20 aspiring HIV Counselors. My observations of the HIV Counselor training best captured the current ambiguity surrounding certain elements of the "3Cs," such as how obtaining consent was explained to trainees. Interviews with the CTE, for example, largely presented this problem as a quick fix (e.g., the need for better specified guidelines). Training observed in action, however, with the opportunity it afforded to observe and hear contradictory attempts at explanation, more forcefully revealed the difficulty in

[63] Also see Fleming et al. 2007 for an evaluation of HTC sessions in rural Malawi.

communicating new, foreign concepts, and helped contextualize the extent to which it may affect how HIV Counselors actually perform their jobs.

Interviews

The most favorable responses to HIV Testing came from the interviews. As others have found of data collected in structured formats in sub-Saharan African settings (Angotti et al. 2009; Angotti, Dionne, and Gaydosh 2010; Thornton et al. 2005), positive responses to interviewers may reflect the respondents' hope that they may benefit materially if they provide what they understand to be the right answer (Miller, Zulu, and Watkins 2001). With this in mind, I adjusted interview strategies to circumvent the regurgitation of official discourse on the "3Cs." Nonetheless, the reliability of reporting merits consideration.

In the interviews, the CTE appears very committed to the rhetoric of the international community. Since the majority was interviewed by me in a formal setting, it is less known what they would say outside of their offices. Notably, the most critical response from a CTE member about testing's guidelines occurred in a conversation that took place at the respondent's home, after having lunch with her family and conversing over afternoon tea. Despite my attempts, however, I was not always fortunate to meet respondents outside of the work place and so I cannot know what they would say in other settings. They may indeed have motives to present to me as on board with the program, though their motives are likely not opportunistic: they have jobs. I am a student and likely not much help to them.

This is not the case for the HIV Counselors, however, and even less so for the villagers. HIV Counselors often tried to impress me as knowledgeable about HIV by repeating the content from their training manuals, and as highly committed to the importance of testing and their roles in advancing it. I thus asked them to explain to me *how* they actually handled the client cases they confronted, such as ones that made them laugh or ones that disturbed them. Albeit a second-hand account, such a recollection got closer to the action itself, revealing their ambivalence about testing guidelines more forcefully.

Interviews with individuals tested for HIV also spoke largely positively about the experience, barring mention of rude health personnel or having to wait long periods of time to be seen. And while it is indeed difficult to ascertain from interviews what respondents really think, unlike the CTE and the counselors, rural Malawian men and women do not have a stake in hewing to the party line. Thus, they may be more frank in their perceptions about the testing process, but still hopeful that they may ultimately be helped materially in some way.

Thus, very generally speaking, the interviews showed that the CTE largely support HIV Testing's guiding principles ("3Cs"); HIV Counselors honor them, but are nonetheless troubled by them; and villagers are largely indifferent to them if their primary goal of receiving care is achieved.

Focus group discussions

Responses also varied in the focus group discussions. I offer two explanations as to why. I attribute the first explanation to how participants were recruited and the second

explanation to the gender composition of the group. I utilized two sets of recruitment strategies for focus group participants. One strategy relied on the Village Headman to assist in recruiting participants in his village; the other strategy involved approaching individuals who were already gathered in natural settings, such as women sitting on a veranda braiding one another's hair or men gathered outside a local canteen. The focus group discussions in which the Village Headman recruited participants generated more of the normative responses that are typical of focus group discussions. By in large, participants spoke positively about testing and were generally in agreement with one another. This was perhaps in the interest of amicably and/or to impress-- either each other, the facilitator and/or the Headman-- with their HIV knowledge and/or about how testing should be done. In one discussion, for example, participants asked the facilitator *his* views on the subject, as if to verify if what they had to say was in fact correct.

Focus groups with participants who were already congregating in natural settings came closest to the types of exchanges observed in the observational field journals. Participants already knew one another since they were already hanging out together and they challenged one another if they disagreed with something someone said. Apart from posing new vignettes, the facilitators were virtually superfluous throughout the discussions. Participants drew upon familiar frames of reference, such as about a notorious HIV Counselor in their village or an infamous witch doctor treating people with AIDS. They were also more critical and seemingly uninhibited about assigning blame to a faulty party: for example, in one focus group, traditional birth attendants were blamed for contributing to the spread of HIV because they will treat pregnant women

without testing them for HIV; in another focus group, participants were critical of young HIV Counselors, whom they said were "drunkards."

The gender composition of the focus group also points to differences in what was learned. For example, in the focus group with all women, the women talked about the extra burdens they carry as women (caretakers for the sick), shared their own experiences being tested during their antenatal care visits, and mentioned how they would exercise agency if their husbands refused to be tested (withholding sex). In the focus group with all men congregating in a natural setting, men were forthcoming about their own reasons for being tested (a "risky" sexual partner), the vices in which they like to indulge (drinking and smoking), and the extreme measures to which they would resort if they were tested but their wives refused to be (end the marriage). In a mixed focus group discussion also occurring in a natural setting, men and women argued and joked about men's refusals to be tested: women said men run away from hospitals, while the men defended themselves and asserted that it is not true of all men.

Thus, the focus groups with villagers show that they see testing as a good thing, but there were significant nuances based on the recruitment strategy and the gender composition of the group. Respondents also seemingly displayed good moral character when speaking with one another, as evidenced in largely favorable responses to the importance of testing (even mandating it), the ethical incumbency on HIV Counselors to not spread one's HIV test result, and the importance of disclosure.

Observational Field Journals

The observational field journals provide actor perspectives without the imposition of an official facilitator or interviewer, perhaps reducing social desirability bias common in interviews and, to a lesser extent in this study, focus group discussions. My use of the observational field journals, however, was somewhat unique. Since the journals I selected for this analysis were written by a field assistant who is also an HIV Counselor, he has the advantage (though it is indeed a methodological disadvantage to the extent that he is not an object of study) of presenting himself throughout the corpus of the texts as well-trained and a good, moral person.

Nonetheless, like participant observation, the journals also document observations and conversations occurring in real time and space, which included the informal conversations between and among HIV Counselors, clients, their families and other health workers. This offered a more dynamic picture of the HIV Counseling and Testing process, specifically the point at which counselors and clients interact. As seen in Chapter 3, for example, the most critical responses to the "3Cs" came in informal conversations among counselors, who mentioned breaking them to protect a family member and who were critical of people who hid their HIV status from their partners. The journals also capture not only hypothetical conversations where an HIV Counselor would break the rules, but actual cases in which they did. Finally, the journals reveal the greatest ambivalence about testing (and treatment): for example, people challenge one another when one person says something another perceives as implausible or unfair,

such as in the case of the group counseling discussion about ARVs provided in Chapter 4.

In sum, like participant observation, the journals reveal more negative reactions to testing than in the interviews and focus groups, illustrate instances of counselor subversion of the rules, and more vividly capture the differential ways in which clients and HIV Counselors perceive the HIV Testing encounter.

WHAT'S NEXT TO COME?

In the ARV guardian waiting area of the M'Dindi District Hospital, three women arrive from a training they just attended hosted by the Clinton Foundation.[64] The first and third women were assisting the second woman with information on how to get a CD4 count to determine her eligibility to begin ARVs. Following their advice, the second woman promptly heads to the appropriate section of the hospital ward to meet with the ARV clerk. After she leaves, the first and third women talk about her: the third woman says she suspects something might be fishy (though she does not elaborate) and mentions that one has to already be taking ARVs to participate in the training for which they had all been selected to attend. She asserts that she is much better equipped to talk to people in her community about HIV and ART than the second woman.

While they chat, a fourth woman, tall and frail, arrives at the ARV dispensary. She greets the first and third women familiarly, smiling widely and shaking their hands. Surprised to see her, the third woman asks: 'Do you also come here? How come I

[64] The William J. Clinton Foundation was established in 2001 to address four primary global issues through partnerships among government, business, NGOs and private citizens: alleviating poverty, improving global health, strengthening the economy and improving the environment (http://www.clintonfoundation.org/about-the-clinton-foundation/.)

haven't seen you here [before]?' Not entirely facetiously, she adds: 'This hospital is mine!' All three women laugh.

The conversations among these HIV positive women outside the district hospital's ARV ward provides a window into what we may expect next in the unforeseen effects of the global AIDS response in sub-Saharan Africa: the benefits that accrue to those who come forward for testing and who are certified as HIV positive.[65] It suggests that people will gossip, get jealous, and surmise as to how someone is eligible to reap the rewards of Western donors when they do not fit the criteria. Just as the AIDS industry in Malawi has bolstered the livelihoods of national elites and, to a lesser extent its civil servants, HIV Counselors, HIV positive villagers might be the next cadre of individuals to benefit from Western donor aid and interest in AIDS in SSA. Their exchange also suggests that the material incentives for individuals to come forward (and go public) as HIV positive might be more important in this setting then the purported concerns about stigma circulating in the global AIDS community (Nguyen 2002).

As indicated in the exchange below, rural Malawians have already begun to recognize the (material) rewards from which HIV positive individuals benefit, efforts akin to attacking stigma with carrots:

[65] Incidentally, at the time of writing this dissertation, a Malawian colleague sent me an email message asking if I could utilize my expatriate networks in Malawi to recommend him for a job with the Clinton Foundation. They were recruiting a "District Supervisor" for a separate category of workers called "expert clients" – those living with HIV and trained to mentor their peers in the community on how to access and better understand ARVs.

> Woman #4: The good thing about testing is that you get assistance from the government such as business and that they do not disclose your status to the public. In the previous years, HIV positive people were being discriminated against. They cannot drink water with you or even stay in the village. Currently if you are HIV positive you are like a boss…
>
> Woman #5: [adds] You receive chiponde [peanut butter] from the government and also ARVs. You look good and healthy. [Mixed_fgd_#3, 2009]

A representative from an NGO working in home-based care for HIV positive individuals explained to Kondwani about enrolling people in their program:

> We get reports from other ARV patients that they saw so and so receiving ARVs. Then they inquire if the person is registered [in our program] or not. When that happens, we approach the person and enlighten him or her that it is important that they register with us so that they can be able to be part of the people to benefit from the help that HIV positive people receive. There are other people who just come forward in the open because they see what their friends receive. Currently I have 160 HIV positive people in my register… they would receive soap, sugar and other food items.

As indicated above, my first prediction of 'what's next to come?' has to do with the creation of new possibilities for those who test for HIV, come forward as HIV positive, and motivate others to test. These individuals may be the next cadre to benefit from ties to Western donors, if not for the short-term. The phenomenon of "coming out" as HIV positive is certainly not new: it dates back to the gay experience with HIV in many Western democracies, whose aim was to turn living with HIV into a "positive" identity and to break the medical dominance of the epidemic (Altman 2001). The involvement of people living with HIV/AIDS (PLWHA) has long been part of the human-rights based approach to addressing the AIDS pandemic – both in international agreements (UNAIDS 2006) and in Malawi's national strategy (Office of the President and the Cabinet and National AIDS Commission 2003).

But in settings like rural Malawi, the consequences may be beyond the imagination, and certainly the objectives, of its foreign donors (Smith 2003). As the conversations among the women in the opening field note suggest, those who do "come out" as HIV positive reap the rewards of training (both materially if there is a per diem involved and in the skills they acquire) and jobs (if they are fortunate). But they may also become the subject of rumor and disdain by those who see them as benefiting from a disease perceived largely as one that can be avoided. Indeed a survey from rural Malawi found that villagers uniformly prioritize other development concerns over AIDS—such as clean water, better health services and better schools; the HIV positive respondents are only slightly more favorable to devoting foreign aid to AIDS (Dionne, Gerland, and Watkins 2010). Similarly, survey data from 18 other high-prevalence, sub-Saharan African countries show that respondents in 11 of those countries think too much is being spent on AIDS (Dionne, Gerland, and Watkins 2009). It also turns the time-honored notion of confidentiality on its head, as the exercise of entitlement to material resources and recognition makes the privacy of living with HIV impossible (Whyte, Whyte, and Kyaddondo 2010).

My second, related prediction has to do with the impact the intensified focus on *treatment* in the global AIDS community will have on local community relations (both in the health clinic and outside of it) and the development of alternative HIV prevention strategies within rural social networks (for examples see Reniers 2008; Watkins 2004). Currently in the policy world there is tremendous hype surrounding "Treatment as Prevention," a strategy based on a mathematical model published by the WHO, which

proclaimed that universal testing and immediate treatment could, in 10 years, reduce HIV infections by 95% (Granich et al. 2009). Findings from the study suggest that HIV transmission could be virtually eliminated by 2020 in high prevalence countries if it were possible to test everyone once a year and then provide ART to all those who test positive for the virus.

The statement, however, is littered with empirically unexamined assumptions about the feasibility and acceptability of treatment in the settings for which it is envisioned. Indeed, part of the rationale for ART as a prevention measure is that if taken correctly and regularly, ART suppresses HIV viral load, thus making one less infectious. During the course of fieldwork, however, I learned that starting treatment, and adhering to it, is profoundly complicated by the convoluted and time-consuming process it involves. A 2009 report from the Malawi Ministry of Health, for example, found that by the end of March 2009, 245,255 cumulative patients were registered for ART at an ART site; only 158,137 patients, however, were alive and on ART. The rest had died (25,775; 11%), were lost to follow-up (28,393; 12%), had transferred to another facility (32,003; 13%), or were known to have stopped taking ART (939; <1%) (Ministry of Health [Malawi] HIV Unit 2010:1).

In my own attempts to better understand how one starts treatment after testing HIV positive, I met with George, an ARV clerk at the M'Dindi District Hospital, one late afternoon. As we sat together in the ART counseling room, I drew his attention to my notebook, gave him my pen, and asked him if he'd draw for me the steps an HIV positive individual must undergo, from the moment s/he leaves the HIV counseling

room to the point at which s/he reaches the pharmacy for antiretroviral medication. After an hour of circuitous explanation, I emerged with a picture of nothing but scribbles and twisted lines. I learned the following: in the best case scenario – that is, that ARV clerks and clinicians are available (e.g., it is before lunch; they are not attending to other clients; they are actually working on the day a client arrives), and that clients and their treatment partners can afford (both in terms of time and money) the often long journey to the health facility on the days it requires for meeting with the clinician and attending ARV group counseling "lessons"—the process of initiating treatment takes *a minimum* of two weeks. After a patient test HIV positive, they are referred to him [George, the ARV clerk], who books patients to meet with the clinical officer for WHO clinical staging. (If the patient has other health problems, such as another sexually transmitted infection, s/he is sent first to a clinical officer in "Room 2," which handles STIs). After the patient meets with the ART clinical officer, s/he is referred back to the ARV clerk if eligible to start treatment. The ARV clerk then books the patient for ARV group counseling lessons, which occur *only* on Mondays and Wednesdays.

During our conversation, I was dumbfounded by the number of steps and contingencies patients must navigate in the course of starting treatment. And I had the luxury of having the undivided attention of the ARV clerk in the afternoon, after the facility was virtually empty, to explain the process to me in detail and tend to all my clarifying questions and 'what if' interjections. If the process remained rather mysterious to me, even after George's explanation, what must it be like for the clients?

The ostensible mystery and obscurity of the ART process doubtless warrants further empirical investigation. It may mean that no one can have any expectations or be disappointed when the process doesn't work out as promised. Or, it may be that when things do work out, the ARV clerk (and other health workers, for that matter) is seen as doing someone a favor, something about which George boasted to me personally when he was able to help sick individuals that the clinician had overlooked or rendered ineligible for treatment.

My final prediction concerns the impact of the vagaries of donor aid and interest in development activities.[66] As Morfit observes, there has been a shift in NGO jobs to AIDS in Malawi in recent years, with AIDS-related employment providing close to 50% of all NGO employment between the years 2000 and 2005. Morfit's informants say that AIDS is the only place to be these days, corroborating what informants from the CTE suggested in this study. At the same time, however, Morfit's study suggests nimbleness. Those working for food security NGOs, for instance, just shifted to AIDS, and are likely to hop on other bandwagons when AIDS (or rather the global and donor interest in it) declines (Morfit forthcoming). Indeed, this trend has been observed in family planning, and the family planning/population growth advocates who remained committed to the cause consistently try to revive it (United States Agency for International Development 2006). While the tremendous international focus on HIV treatment (as described earlier)

[66] A recent article in *The New York Times* described a lack of donor interest in funding a vaginal microbicide, one that has proved efficacious in clinical trials in South Africa for reducing new infections in women. Tim Falley, a scientist at the WHO, was quoted as saying, "HIV/AIDS is perceived to be very expensive research, and there's a sentiment in the U.K. [among UK donors] that it's time to shift priorities" (Dugger 2010). The article notes that British funding priorities have shifted from AIDS to maternal and child health, tuberculosis and malaria.

suggests that an interest in AIDS will likely continue well into the future, the types of jobs that will emerge, and as a corollary disappear, remains to be fully realized. Some jobs in the AIDS industry are likely to be more flexible than others; for example, an HIV Counselor Trainer with a nursing background may be able to shift his/her skills to *trainings* in ART counseling or to other development projects that are not AIDS-related, such as child protection. Other jobs in the CTE, however, may not be as portable. And, of course, there is a much larger issue hovering in the background and beyond the scope of this dissertation: that donors might eventually object to endlessly funding the increasing number of Africans on ART.

FINAL THOUGHTS

The data collected and analyzed in this dissertation detail the reception of a human rights package with international (Western) origins in a very different (non-Western) setting. In this final section, I consider what each strata affecting the implementation of HIV Testing ("3Cs") finds problematic with the package and, most importantly, why.

The Counseling and Testing Establishment – who receive (and adapt) the rules from Geneva to Malawi -- basically do not interact at all with people living with HIV/AIDS.[67] Rather, they interact with donors and other elites. They write policies, strategies, guidelines and reports from their desks. It is thus not surprising that the CTE hew closest to the language of human rights: the idea that antiretroviral treatment is a right, that testing is a prerequisite for treatment, and that testing is only proper if it

[67] By this, I mean the targets of their efforts, not family members or friends who are HIV positive.

includes consent, is confidential, and offers pre- and post-test counseling. The CTE largely accept the whole package, with only the occasional qualification that '*xxx*' might be a problem. They don't see what happens in day-to-day practice and do not have to deal with real clients: the closest they come are the guidelines to train HIV Counselors who deal with real clients and the occasional (quarterly) routine supervision of test sites that help them evaluate their programs for their reports. While the problems they do see with the "3Cs" varied, by in large, their biggest concern seems to be that of *consent*, namely what they see as the public health consequences of insisting on strictly voluntary testing (i.e., the infected won't get access to treatment). Moreover, since consent is the most contentious "C" in the global AIDS community at the moment, it is an issue that keeps the CTE's current work in the AIDS industry in Malawi active and important.

In contrast, HIV Counselors *do* interact with clients, and what is more, they live in the same setting as them. Although it is very important to the HIV Counselors to maintain their identity as professionals, as experts, and as being in command of the rules, because they are up close with the clients, they can see the problems with the "3Cs" in a way that the CTE just cannot. And, because they live in the same setting, they are more attuned to the mismatch between the "3Cs" package and the norms of the communities in which they live. Consequently, counselors have their own ideas about what can be done: when a wife, for example, threatens not to be a guardian for her sick husband, they might acquiesce and break confidentiality because they know what it means if the wife were to leave and not change her husband's sheets, feed him, and escort him to the hospital for medication. Significantly, counselors also have a

reputation in their communities to protect. Thus, their primary concern appears to be *confidentiality*.

For the villagers, public health is an issue, but from a much more personal perspective--not so much public health for the sake of the health of their community, but rather their own health, and the risks they face because they cannot see who is HIV positive. Villagers do not have a commitment to human rights at all: their identity is not related to connecting with the global community (as is the case with the CTE), nor to mastering foreign jargon (as is the case with the HIV Counselors). Thus, they have nothing to gain from defending them. They simply do not want to be forced to be tested; they don't want HIV Counselors to disclose their results (they want to control disclosure themselves); and they are not particularly interested in the counseling they receive as they know it already (and it largely resonates with them as improbable and undesirable) and would rather have a shorter wait time in the clinic and health personnel who do not shout at them.

In sum, this dissertation demonstrates that attempts to address problems from afar are not likely to match what happens on the ground. Moreover, since the problems as seen from the perspective of each stratum of actors are likely to be different, the adaptations by implementers in practice will be different, as will the responses of its intended beneficiaries. It is therefore important for policy makers and analysts to recognize and understand the differing perspectives, rationalities, aspirations, motivations and concerns of the various strata affecting the implementation of an intervention. Indeed, unless those exporting a package know something about this, it is

unlikely to have its intended effects. Thus, this study, at its core, illustrates that interventions aimed at improving the human condition are thoroughly affected by the context in which they are pursued.

Timeline of Key Events

1981: Scientists in the U.S. document clinical evidence of a disease later identified as AIDS

1985: The first HIV antibody tests are commercialized in the US and in Europe; HIV screening of blood donations begins

First AIDS case in Malawi is diagnosed. The government subsequently adopts a blood screening policy and public education strategy

1987: World Health Organization establishes Special Programme on AIDS

AZT is approved for use in the United States

The AIDS Support Organization (TASO) is formed as Africa's first AIDS-based community organization

1988: Health Ministers from around the world meet in London and discuss the AIDS epidemic for the first time

1989: First international consultation on AIDS and human rights is organized by the United Nations Centre for Human Rights, in cooperation with the World Health Organization/Global Programme on AIDS. They issue *Report of an International Consultation on AIDS and Human Rights*

The Malawi government establishes the National AIDS Control Programme (NACP) within the Ministry of Health and Population

1992: UN Resolution WHA45.35 recognizes that there is no public health rationale for measures which arbitrarily limit individual rights, such as mandatory screening

Malawi Ministry of Health and AIDS Control Programme develop *Counselling Guidelines and Policies* (first edition)

1995: Malawi AIDS Counselling and Resource Organization (MACRO) begins testing services

1996: The Joint United Nations Programme on AIDS (UNAIDS) is established

UNAIDS and the Office of the United Nations High Commissioner for Human Rights (OHCHR) issue *HIV/AIDS and Human Rights: International Guidelines*

1997: UNAIDS issues *Policy on HIV Testing and Counselling*

1999: President of Malawi launches National Strategic Framework and declares HIV/AIDS a national emergency

2000-04: NAC, MOH and other stakeholders (with support from donors) jointly establish policies and guidelines that further provide guidance in the delivery of HIV and AIDS services (VCT is included as a thematic area)

2000: Rapid blood tests for HIV are introduced in Malawi by the U.S. Centers for Disease Control (CDC)

2001: The National AIDS Commission (NAC) is established in Malawi to replace the NACP and to coordinate a multi-sectoral implementation of the strategic framework

2002: The Global Fund to Fight AIDS, Malaria and Tuberculosis (Global Fund) becomes operational. Malawi receives Global Fund approval for $196 million over 5 years to fund treatment, care and support activities

2003 U.S. President's Emergency Plan for AIDS Relief (PEPFAR) is established

Malawi Government releases a National HIV/AIDS Policy, *A Call for Renewed Action*

2004: WHO/UNAIDS issue *Policy Statement on HIV Testing* ("3Cs")

Malawi Ministry of Health develops *HIV/AIDS Counselling and Testing: Guidelines for Malawi* (second edition)

Malawi Ministry of Health develops *Voluntary Counselling and Testing: Site Counsellors Handbook* (second edition)

ART is made free in Malawi with support of Western donors

2007: WHO/UNAIDS issue *Guidelines on Provider-Initiated HIV Testing and Counselling in Health Facilities*

Malawi develops a revised training manual, *HIV Testing and Counselling: Training for Site Counsellors* (third edition), which integrates HIV counseling and rapid blood testing

Appendices 1: Interview Protocols

Appendix 1.1 Counseling and Testing Establishment

Background Information

- Can you tell me about yourself? How did you get this current position? What were you doing before?

Involvement with HIV Counseling and Testing

- What was your role in the development of [policy document, training manual, etc]?
- What is the role of your organization in the development of [policy document, training manual, etc.]?
- Where did you stand on the matter? What were you advocating for?
- Where did others stand?

Implementation of HIV Testing

- How are HIV Counselors recruited?
- How are they supervised and how often?
- What is most difficult for the HIV Counselors?
- Why do you think people do/do not want to be tested for HIV?
- Do you visit the testing centers? If so, how often? What are you looking for?
- What are the biggest challenges in promoting HIV Testing? What would you like to see changed?

Testing Guidelines- Consent, Confidentiality, Counseling

- What is meant by consent? By confidentiality? By counseling?
- Have there been any changes to these principles? If so, what, when and why?

Concluding Thoughts

- Is there anything else you'd like to share with me?

Appendix 1.2: HIV Counselors

Background Information

- Can you tell me about yourself? Where did you grow up? Where did you go to school? Parents? Siblings?
- How did you decide you wanted to learn to be a VCT counselor? Had you done some similar work before?

Experience with HIV Counselor Training

- By whom were you trained as a VCT counselor?
- When you first started as a VCT counselor, what were the hardest parts of your job?
  The easiest? The most interesting?
- Was your training good? What things did you have to change or do differently when you actually started the counseling?

Experience as an HIV Counselor

- Where do you work as a VCT counselor? Is this the community from which you come?
- Now that you have been doing it for some time, what is hardest? Easiest? Most enjoyable?
- Now I want you to think about how you learned what VCT is supposed to be. What were the most important points?

Voluntary/Informed Consent

Tell me about the "voluntary" part of VCT:

- What does it mean?
- How do you think clients understand voluntary?
- Are there times when people get tested even when they don't really want to? Like at the hospital?

Confidentiality

Tell me about the confidentiality part of VCT.

- What does it mean?
- How do counselors maintain confidentiality?
- How do you think the people you counsel understand confidentiality?
- Is there anyone else who sometimes feels that he or she should be able to know someone else's test result? What about a son or daughter wanting to know a parent's result? Has this happened with someone you counseled, or did a fellow counselor tell you about it?

Counseling

Tell me about the counseling part of VCT.

- What is the main focus of counseling?
- How do your clients understand counseling?
- What do you talk about before the test (pre-test)?
- What do you talk about after the HIV test results are given (post-test)?
- What do your clients know about HIV/AIDS? What don't they know? What do you believe is most important for them to know? Why?

VCT Sessions with Clients

Tell me about your last VCT session:

- Describe the client: Age? Sex? Marital Status?
- Why did he/she come for HIV testing? Was it his/her first time?
- What was the best part of the session?
- What was the biggest challenge with this session?
- What would you have done differently?
- What did your client know about HIV/AIDS?
- What did you say to your client when the session began?
- What questions did you ask the client?
- What questions did the client ask you?
- Did he/she accept the results? Can you describe his/her reaction?
- Did he/she plan to share test results with someone? With who? Did you encourage disclosure of results?

Tell me about your last session with a client who tested HIV positive.

- [Repeat questions above]

Tell me about your last session with a client who tested HIV negative.

- [Repeat questions above]

Tell me about a session that troubled you, a session that made you laugh.

Concluding Thoughts

- Is there anything else you'd like to share with me?

Appendix 1.3: Village Headmen

Role as Village Headman

- What types of issues/problems are you faced with in your village?
- How do you resolve issues presented to you?
- How do you determine the 'right' thing to do?

HIV/AIDS

- Have people in your village come to you with concerns about HIV/AIDS? If so, what types of concerns?
- Has anyone come to your village to talk about health related issues? Issues specific to HIV/AIDS?

HIV Counseling and Testing

- Have you advised people to go for testing? If yes, in what situations? If not, why? [Examples] When was the last time it occurred? What happened?
- Have you ever resolved disputes in your village about HIV testing? If so, what were they? [Examples] When was the last time it occurred? What happened?
- If you could make results public or private, which do you think would be most beneficial to your village's health, both physical health and social health?

Appendix 1.4: HIV-Tested Clients (Villagers)

Introduction
Establish rapport anyway you can.

Personal and Family Health
Chat with the respondent about his/her personal health, the health of his/her family members, and their experience(s) accessing health services.

Registered VCT Visit
Chat with the respondent about what led him/her to the health facility the day of his/her registered VCT visit.

Experience with VCT
Chat with the respondent about his/her experience being tested for HIV. Get the respondent to describe to you, in detail, what the process was like.

Transition to ARVs
Chat with the respondent about what he/she knows about ARVs and what he/she thinks about those services.

Health Services
Chat with the respondent about what he/she thinks will make his/her village healthier.

Appendix 2: Focus Group Discussion Protocols

2.1. Focus Group Vignettes

[**Consent**]
Lucy is pregnant and goes for antenatal services for the first time. When she goes to the antenatal clinic, what do you think will happen?

[**Confidentiality**]
Your sister [or brother] told you that she [he] recently saw your husband [or wife] at the VCT clinic. When you confront him [her], he [she] says no, he [she] wasn't there. The VCT counselor at the clinic is a friend of yours. You go to her house and ask whether your husband was tested and his result. What should the VCT counselor, who is also your friend, do?

[**Counseling**]
Mphatso and Veronica want to get married. The church pastor says they must go for VCT first. What do you think will happen at the testing center?

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